HCBS Autism Waiver
Individualized Behavioral Program/Plan of Care

Section I - Demographics

1. Date of IBP/POC _____

HCP/CSS Office Use Only
Exception Date Rec'd:_____
Initials: _____

Initial IBP _____ Revision_____

Year 2_____ Year 3 _____ Exception _____

2. Child's Information

Name of Child_____
Medicaid Number: _____ Social Security Number: _____
Street Address: _____ City: _____
County: _____State: _____ Zip: _____ Phone number:_____
Date of Birth: _____ Gender (circle one): **M** F

3. Parent / Legal Guardian Information

Name of Parent or Guardian: _____
Street Address: _____ City: _____
County: _____State_____ Zip: _____ Phone number: _____
_____Natural / Adopted Parents ____Foster Parents ____ Guardian ____ Child is in SRS Custody

4. Autism Specialist Information Provider No:_____

Name of Autism Specialist Provider: _____
Work Phone Number: _____ Work Fax Number: _____
Work Street Address: _____ _____
City: _____ County: _____ State: _____ Zip: _____
Email Address: _____
Independent Provider_____ Agency Provider_____
**** Note: Complete section 5 if the Autism Specialist is employed by an agency.

5. Agency Information Agency No: _____

Name of Agency: __ _____
Work Phone Number: _ _____ Work Fax Number: _____
Work Street Address: __ _____
City: _____County:__ _____State:_____Zip:_____
Type of Provider (choose the one that best describes your agency)
____Developmental Disability _____Mental Health _____Child Welfare

6. Assessment Score & Diagnosis:

Date the Vineland II Adaptive Behavior Scales was completed _____
mm/dd/yy

VINELAND II ADAPTIVE BEHAVIOR SCALES

Adaptive Areas:		**Maladaptive Areas**:		**Diagnosis:**
Communication	_____	Internalizing	_____	_____
Daily Living Skills	_____	Externalizing	_____	_____
Socialization	_____	Total	____	
Motor skills	____			

Must have a total score or a score on any two elements of the Adaptive areas below the score of 70 **OR a total score or a score on any two elements of the Adaptive area score 70-85 and the maladaptive score on the internal, external or total is 21-24.

7. Criterion Reference Skilled Based Assessment

Name the type of Criterion Reference Skill Based Assessment utilized.

_____

8. Treatment options

Which evidence-based method is currently being used, or is planned for use for the early intensive intervention?

ABA (e.g. pivotal response training) _____
DTT (Discrete Trial Training) _____
TEACCH (Treatment and Education of Autistic and Communication-Handicapped Children) _____
RDI (Relationship Development Intervention) _____
Other evidenced-based practice _____

9. Classroom or Educational Setting

Does your child receive any mandated services? _____ Yes _____ No
If so, provide name of school/service?
What grade are they in? 2nd

10. Behavior Impact Rating Tool

Interviewer, say to parent: *"Parent, using the following rating scale, please rate how satisfied you are with the impact of your child's needs on your and your family's daily life. Please base your responses on your child's worst day".*

Very Dissatisfied	Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Satisfied	Very Satisfied	N/A
1	2	3	4	5	6	


Questions	Rating
1. My ability to take my child out in the community (ex. Grocery store, park, doctor's office, etc.).	
2. The extent to which my child effectively follows the directions given:	
3. My level of exhaustion at the end of the day.	
4. How will I handle my child's problem behavior across settings?	
5. The ability to leave my child with other people (babysitter, family, etc.)	
6. The strategies I currently use to stop the problem behavior when it is occurring.	
7. The amount of time I have to do things for myself.	
8. My understanding of why my child is engaging in problem behavior.	
9. The preventative strategies I use to lower the likelihood of problem behavior.	
10. Each person on the team's interactions with my child (i.e. everyone is consistent).	
11. My family's participation in community activities. (Ex. Church, school events, etc).	
12. My child's ability to communicate his/her wants and needs	
13. My child's friendships or interactions with typical peers and/or siblings.	
14. Our family's ability to interact with friends at their or our house.	

Very Dissatisfied	Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Satisfied	Very Satisfied	N/A
1	2	3	4	5	6	

Questions	Rating
15. My child's progress with his or her current educational services.	
16. Our ability to balance our family's needs with my child's needs.	
17. The ability of my child's current school or child care to address his or her individual needs.	
18. The intensity of supervision my child needs.	
19. My child's ability to do things for him/herself (ex. self-help skills, such as hand washing, toileting, sleeping, eating, etc.).	
20. The frequency, severity, and/or intensity of my child's problem behavior.	
21. My other children's feelings about my child (i.e. siblings).	
22. My child's overall happiness and quality of life.	
23. Others' perceptions of my parenting and disciplinary skills.	
24. The extent to which the child's problem behavior affects the relationship between my significant other and me.	
25. My ability to access support from professionals and/or network with other parents in similar situations.	
26. My ability to cope with stress and other issues related to my child (i.e. emotional well being).	

(modified from Behavior Impact Rating Tool 2007 ALT)

Please list the number of the preceding items that correspond to your 5 highest priorities.

1.____20_____
2.____17_____
3.____13_____
4. ____1_____
5.____8_

Please list the top 3 problem behaviors to address.

1. Perseverating on Movies
2._Engaging in verbal protest
3._Engagin in aggressive behaviors

11. Global Risk Rating Scales: Consider the previous information and what you know about the child's entire behavioral repertoire. Use the rating scale below to indicate the child's overall risk levels.

Strongly Disagree  Strongly Agree

1 2 3 4 5

Questions	Rating
1. The child's behavior is dangerous to others	
2. The child's behavior provides a health risk to self (i.e., head banging, self-biting, etc.).	
3. The child's behavior results in significant damage to property.	
4. The child's behavior is likely to become serious in the future if not addressed.	
5. The child's behavior is occurring at such a frequency or intensity that a caregiver's ability to effectively provide support is being compromised.	
6. The child's behavior results in the involvement of law enforcement	
7. The child's overall behavior puts them at risk of institutionalization or loss of a. current least restrictive environment, such as at home or at school.	

Section III – Circle of Support

Emergency Contacts - (In the event of an evacuation or scheduled staff is not available to work, who would be your emergency contact and/or back up plan to care for your child. Please list in order of priority.

1. Name	Address	Phone & Alternative Number	Relationship to child

List the members of your household

2. Name	Address	Phone & Alternative Number	Relationship to child

Additional Non-Waiver Support /Services from Family, Friend, Neighbor, Church,

3. Name	Relationship (check if primary caregiver)	Address	Phone	Service	Frequency	Paid	
						Yes	No

Section IV **HCBS Autism**

HOME & COMMUNITY-BASED SERVICES FOR AUTISM SERVICES
PLAN OF CARE

1. POC Approval Date

2. Child's name: _____ SS#:_____ Medicaid #:_____ DOB_____

Address: _____ City: _____ Zip: _____ County_____

Identified Autism Specialist: _____ Provider Number_____ _Phone#_____Vineland II Assessment Date_____

3. Plan of Care

Waiver Services	Procedure Code	Provider Number	Provider Name	Units (15 min. = 1 unit)	Frequency	Total Units Monthly	Services Start Date	Services End Date	Discharge code	Cost Of Unit	Monthly Cost
									Total Monthly Waiver Cost		

4. Client Obligation Amount if Applicable (assign to a specific provider) $_____
5. Assigned Provider(s) number. _____ (1) _____ (2)

Release of Information: I consent to the release of the information on this page so my child can receive services. I understand the information included in this document will be release to Waiver Service Providers listed above to enable the delivery of services and program monitoring. My signature on this form also certifies that I agree to and helped develop this plan of care.

6. Signatures

_____ _____ _____ _____
Parent / Guardian Signature Date Autism Specialist Date

_____ _____ _____
Print Name Relationship Print Name

*******Signature must be legible *********

Section V – Participant Signature Page

Print Name	Signature	Relationship to child	Date

Print Name	Signature	Relationship to child	Date

Additional domain sheets are included in the Appendix 1.