DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00926 (02/2017)

STATE OF WISCONSIN
Wisconsin Statutes
§ 51.61(1)(i)
Administrative Code
DHS 94.10

REQUEST FOR USE OF RESTRAINTS, ISOLATION, OR PROTECTIVE EQUIPMENT AS PART OF A BEHAVIOR SUPPORT PLAN - CLTSS

Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Personally Identifiable Information is collected on this form for the sole purpose of identifying the waiver participant and processing the request, and will not be used for any other purpose.

Name - Consumer	Birth Date	Type of Request ☐ New ☐ Review	
Current Address - Consumer	City	State	Zip Code

Individual's Applicable Target Group(s) (check all that apply): ☐ CLTSS-DD ☐ CLTSS-PD ☐ CLTSS-SED

Name – Parent/Guardian	Telephone Number - Parent/Guardian

Current Residence - Consumer

- ☐ Personal/Family Residence *(Same address as above)*
- ☐ Licensed or Certified Facility, e.g., Foster Home, Adult Family Home, Shift Staff Treatment Foster Home *(Provide name and address below.)*
- ☐ Other *(Describe and provide address below.)*

Residence Street Address (if different from above)	City	State	Zip Code

1) Name – Waiver Provider/ Agency that will use the restrictive measure

Waiver Service Type and Frequency

Address- Waiver Provider/Agency			Telephone Number
City	State	Zip Code	Fax Number

Email Address

2) Name – Waiver Provider/ Agency that will use the restrictive measure

Waiver Service Type and Frequency

Address- Waiver Provider/Agency			Telephone Number
City	State	Zip Code	Fax Number

Email Address

County Waiver Agency Submitting This Request			Date Submitted
Contact Person/Support & Service Coord.	Telephone Number	Fax Number	Email Address

Address – Agency	City	State	Zip Code

Definitions

Check “Yes” or “No,” if the following apply.

Yes	No		
☐	☐	**Physical Restraints**	Any device, garment, or physical hold that (a) restricts voluntary movement of a person’s body or access to any part of the body **and** (b) cannot be easily removed by the individual.
☐	☐	**Isolation**	Physical or social separation from others by actions of staff but does not include separation in order to prevent the spread of communicable disease or cool down periods in an unlocked room as long as presence in the room by the resident is voluntary
☐	☐	**Protective Equipment**	The application of a device to any part of a person’s body that *prevents tissue damage or other physical harm* due to a person’s behavior **and** cannot be easily removed by the individual.

If the answer to any of the above definitions is “**Yes**,” continue.

Personal Summary

Type of Daytime Activity/ School Program

Support Systems

Interests

Dislikes

Health Considerations

Diagnoses

Health Concerns

Height: Weight:

Medications

Medication	Dose	Purpose	Prescribing Physician

Health Providers

Specialty	Name	Address	Telephone
Primary Physician			
Psychiatrist			
Psychologist / Therapist			

Neurologist			
Other			
Other			

Target Behavior

Please attach copy of current Behavior Support Plan

Describe or attach the person's challenging behaviors and the situations in which they occur.

Describe or attach the frequency and intensity of the above behaviors.

Describe or attach the patterns that have been observed when the behavior occurs, i.e., what triggers the behavior.

Describe or attach the plan currently being done proactively to prevent these behaviors from occurring.

Previous Support Strategies or Interventions

List and explain or attach previous support strategies or interventions, when they were tried, how long they were tried, and the outcomes.

1. Support Strategy

   Outcome

2. Support Strategy

   Outcome

3. Support Strategy

   Outcome

4. Support Strategy

   Outcome

Current and Proposed Strategies

Describe or attach the current and proposed strategies and safeguards for target behaviors. Include staffing patterns, level of supervision, restrictions, or limitations. Attach the current support plan / behavioral support plan, OT and PT evaluations, physician orders, informed consent by the consumer or guardian.

What is the need?

Explain or attach why the current strategies are ineffective. Describe what more is needed.

Risks and Benefit

Describe a risk and benefit analysis for the use of the restraint, isolation, or protective equipment.

Restraints, Isolation, or Protective Equipment

Identify proposed procedure or device and why these strategies are needed.

Attach relevant photos, manufacturer specifications, or literature.

Procedure / Device	Purpose	Plan *(Specify where procedure or device used, when, length of time, etc.)*	Desired Outcome

Physician Orders

Include written authorization by a physician, identifying the type of restraint ordered, the indication for its use, the time period for its application, and any potential considerations for the use of the proposed restrictive measure.

Intervention

Describe or attach the sequential process during which less restrictive measures will be used that precedes the use of restraints.

Reduction And Elimination Plan For Restraints, Isolation, or Protective Equipment

Describe or attach the plan for reducing and eventually eliminating the need for restraints.

Training

Describe or attach the plan to provide initial and on-going training for staff. Identify who will conduct the training, his/her credentials, the duration of training, and how the training will be documented.

Review

Describe or attach how the plan will be monitored, documented, and reviewed.

Individuals Having Input Into the Support Plan

Name	Relationship to Consumer

Plan Review

Plan Reviewed By	Name	Signature	Date Reviewed
Parent /Consumer (if over age 18 and not under guardianship*)			
Guardian, if applicable*			
Placing Agency*			

Provider Agency*			
Behavior Consultant or Specialist			
Primary Physician**			
Other			
Other			

* Required signatures
**Required signature unless signed doctor’s order or prescription is included with application