

Ohio Department of Developmental Disabilities
Eligibility Assessment for the Behavior Rate Add-On for Routine HPC and Community Respite Services

(This form is **not** for state-funded requests and is not mandatory)

Individual's Name:

Name	
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The purpose of the behavioral support rate modification is to provide funding for the implementation of behavioral support strategies by staff who have the level of training necessary to implement the strategies for individuals receiving Homemaker Personal Care or Community Respite and enrolled on the Individual Options (IO), Level One, or SELF Waiver.

1. Has the individual been assessed within the last 12 months to present a danger to self or others and/or have the potential to present a danger to self or others?

If "No" Stop here

If "Yes" Identify:

Type of assessment: _____
Date of assessment: _____
Title/name of assessor: _____

2. Is a behavioral support strategy that is a component of the ISP developed in accordance with the requirements in rules established by DODD?

If "No" STOP HERE – the individual does not meet the criteria for the add-on.

If "Yes" identify the behavior support strategies or provide a snippet or brief summary from the ISP:

3. Does the individual meet **one** of the following criteria?

Check Yes or No to each:

<input type="checkbox"/>	Four or more yes responses on item #32 of the ODDP.
<input type="checkbox"/>	Requires a structured environment identified in the ISP that, if removed, will result in the individual's engagement in behavior destructive to self or others.

If "No" to both STOP HERE – the individual does not meet the criteria for the add-on.

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If "Yes", to either briefly describe the support services or provide snippet from ISP:

If items, 1 and 2, have been answered "yes" and there is one "yes" response to item 3, then the person will qualify for the Behavior Support Modification (Behavior Add-on).

Qualifies for county funded Behavior Support Modification to HPC/Community Respite Rate:

Choose Yes or No

Assessment Completed by:

Date Completed:

Confirmed By:

, Supervisor