POSITIVE BEHAVIOR SUPPORT ASSESSMENT (PBSA) GUIDE

The PBSA is the cornerstone of BSC work. Through its development we hope to gain a holistic and dynamic perspective on the many factors that contribute to an individual's current position in the world and the important variables that affect their behavioral communication. Without the PBSA there can be no Positive Behavior Support Plan (PBSP).

A BSC may bill up to 20 units for the initial/annual formulation and an additional total of 20-units/ISP year for any rewrites as deemed clinically necessary.

The balance of the BSC units that may be requested and factors that may influence this total are addressed in the Determination of Needed BSC Units Per ISP Year section near the end of this guide.

PLEASE NOTE: *The italicized text in this document is meant to guide your completion of each section. The italicized text should not appear in your completed PBSA. Retain all* non-italicized text and headings *except in some areas where some may be removed as explained in the description of that section.*

I. Identifying Information: *Every line of this section is required by the Health Care Authority. Do not leave any blanks:*

INDIVIDUAL'S NAME:		REGION OF RESIDENCE:	
DATE OF BIRTH:		RESIDENTIAL AGENCY:	
LAST 4 OF SSN:		TYPE OF RESIDENTIAL SUPPORTS:	
HOUSEHOLD ADDRESS:		SUPPORTED LIVING CATEGORY OR N/A:	
HOUSEHOLD PHONE:		CCS AGENCY:	
CASE MANAGER/AGENCY:			
CASE MANAGER PHONE:		ANNUAL ISP DATE:	
GUARDIAN:		DATE OF THIS REPORT:	
GUARDIAN PHONE:			

The remainder of this guide follows the format of the PBSA Template:

II. DIAGNOSES

BSCs are not permitted to diagnose individuals on the Waiver. The information in this section must come from another source – e.g., the ISP, the psychiatrist etc. Please note the source.

a. Current Psychiatric Diagnosis

b. Diagnostic Impressions

A BSC can however, write as they please in the Diagnostic Impressions section if they feel certain psychiatric diagnoses are misplaced, in conflict with each other, or missing.

c. Previous Diagnoses

d. Current Relevant Medical or other Physiological Issues

This may take some investigation. You may not be familiar with all of the physiologic or genetic conditions listed in the person's record. Do some research, ask other providers, and list/briefly discuss any that seem to or could be influencing a person's behavioral communication, mental status, or confusing the mental health presentation.

III. CURRENT MEDICATIONS (ATTACH MAR)

A complete listing of the medications an individual is taking as of the date on the report. Name, dosage, administration times, and why prescribed should all be included.

IV. REFERRAL INFORMATION

In this section describes how you became involved with the case, where the first information came from, and other sources of information used in the completion of the PBSA.

- **a. Reason for Referral**
- **b. Referral Source**
- **c. Individuals Contributing Information**
- **d. Records Review**

V. RELEVANT FACTOR: INDIVIDUAL ATTRIBUTES

- **a. Biological or Physiological Factors**

  Take some time here to define any physical/medical diagnosis(es) the person may have. Remember your audience. The staff may know that a person has Cerebral Palsy, but do they know what CP is? State the condition and then give a plain language definition of the condition and possible symptoms. Do the same with any/all medical and psychiatric conditions. Stay basic but give the reader an idea of how the condition may affect behavior.

- **b. Problem Solving Capacity and Means**

  Is the person normally oriented to identity, time, place, season, activity? Does the person understand the normal course of the day, week, month, and year? If the person can follow directions/requests – is there a limit to the number of steps they can handle at one time? Does the person try to figure out problems on his or her own? If so – how effective are they?

- **c. Intellectual Status**

  Can the individual make assertive choices as to what they do/do not want to do? How can they express this choice? If they can – do they? If not, why? Once the person makes a choice, are they able to effectively follow-through? Can they transition from one activity to another without significant difficulty?

- **e. Cultural Issues**

  Are there specific cultural identifiers or group affiliations that the individual uses or subscribes to that are pertinent to the individual's support?

- **f. Spiritual Beliefs**

  Does the individual have any religious or spiritual preferences? Are they able to engage in these activities or do they need more support? Does the individual have any preferences in their appearance or the appearance of their surroundings? How do we know these things – are they telling or are we guessing?

VI. RELEVANT FACTOR: RELATIONSHIPS AND ASSOCIATED SKILLS

- **a. Communication**

  How does the person communicate? – Both at their best and at their worst. Verbal abilities and how they change depending on stress. Non-verbal style of communication is also important to note. Interface with and refer to the SLP and SLP plan if one is available.

- **b. Social Competence**

Does the person seem to be interested in social activities/contact? What do they seem to prefer in social interaction – one-to-one or groups? Does the person have knowledge of stranger/acquaintance/friend and how these roles change over time? Does the individual understand the progression of conversation and some basic social scripts? Does the person display adequate social boundaries and limitations? For individuals who cannot/do not speak or directly communicate try to describe how they interact with the world and who they seem to prefer from a social/support perspective.

c. Self-Regulation

Everybody gets stressed and everybody has his or her own ways of de-stressing. Some techniques are effective and non-harmful (deep breathing). Other methods may be effective but potentially harmful (punch the wall). In this section try to list the different ways the person seems to regulate their own needs/comforts. Divide into subheadings of 'Most Adaptive'; 'Less Adaptive' and 'Potentially Harmful'.

d. Emotional Status

Think 'affect' more than mood. Affect is what you can observe in a person's countenance and body language that may give a window to their emotional world. Does the individual display a wide variety of emotion or are they 'restricted' in their affective appearance? Does their affect match their likely emotion or is it incongruent (laughs when encountering a sad event)? How does the person handle a variety of emotions? Can the person verbally express a variety of emotions or is their emotional language restricted to 'happy and sad'. How does the person react to emotional distress?

VII. RELEVANT FACTOR: ENVIRONMENTAL

Environment is the single biggest contributor to any organism's behavior. Give some space to each of the supportive environments the individual utilizes – residential, day program, school, employment, natural supports. Provide a description of each of these environments and the components that contribute to their success or failure. Some brief recommendations for improvement may be made but a full exploration of your recommendations should be reserved for the Positive Support Plan.

a. Settings
b. Social Density
c. Lighting and Noise
d. Movement
e. Opportunities to Exercise Independence
f. Opportunities to Engage in Participatory Activities
g. Perceived Level of Satisfaction

Think of the five senses. Does this client have any limitations in any area? Do they seem to not like certain environments or really prefer other environments? What are the qualities of these environments (crowded, loud, bright etc.) that may influence these preferences? If there is an OT on the team – read their plan, talk to them about these areas.

VIII. RELEVANT FACTOR: TRAUMA-INFORMED CONSIDERATIONS

The core principles of trauma-informed practices apply regardless of a person's known or unknown history of experiencing discrete or multiple trauma(s). In some cases, the specific trauma(s) a person has experienced may be a clear factor in building supports. In other cases, perhaps without known or divulged trauma, these considerations may be more generalized but still highly relevant to helping a person build a life of confidence and

belonging. Considering the information you've compiled above – what factors below seem the most relevant as you build toward planning for skill development and quality of life? While not each and every item or question below may be relevant – address the ones that are and add any you see as missing.

a. **Safety**
   Physical, psychological, social, or spiritual considerations. Are there any basic safety concerns in the person's home, work, or social environments? Might there be a need for trauma-specific counseling or pre-counseling (i.e., relationship building, stress-management skills)? Would the individual benefit from skill-building related being able to improve self-care skills? What level of physical contact/personal space seems to be preferred?
b. **Trustworthiness and Transparency**
   How might the individual's history impact her/his/their level of trust in others? (e.g., to be treated well/kept safe, to be listened to, to be included). How important is it for the person to be told the direct truth and in what way?
c. **Peer Support and Relationships**
   How has the person been included or marginalized in social, family, or professional relationships? Does the individual have at least one person he/she/they can talk to privately? Is the person part of any simple social/peer group?
d. **Collaboration and Mutuality**
   Does the person feel like they are part of their own team? Can we improve how we include the person in support planning? Do you think the person has been included as much as possible in this process of assessment? If yes, how might it expand further? If not, what may be first steps to improvement?
e. **Empowerment, Voice, Choice**
   Is the person's voice present in team meetings? In their household? In other environments? How can the person experience more power in their own life or support planning? Are there missed opportunities for choice-making?
f. **Cultural, Historical, and/or Gender Issues**
   Are there any factors related to cultural, historical, or gender issues that have not been addressed? The intersection of trauma with other aspects of marginalization may more easily lead to re-traumatization and disempowerment.

IX. EFFECTIVENESS INDICATOR: COMMUNITY INTEGRATION/QUALITY OF LIFE

Being able to safely access the community and engage emergency services are highly important parts of living an integrated life. Can the individual safely navigate the community? If not- what level of support is necessary to help them get to where they want to go? Do they need one-to-one support due to safety concerns? Do they need help with street safety? How can they access the community services, activities etc. that they prefer? How can they communicate these needs/preferences? Can they effectively access emergency support (e.g. 911)? If emergency response is necessary –how might they respond to the emergency personnel?

a. **Discussion or List of Opportunities to Participate in a Range of Experiences, Events, Settings**
   Are the barriers to the person being able to go to or participate in things they enjoy? How rich or varied are the person's options for getting out into places or activities they enjoy? What services are available to the person to support these activities and options?
b. **Discussion of individual's overall satisfaction**

Does the individual seem to like what is happening around them?

X. EFFECTIVENESS INDICATOR: SKILL DEVELOPMENT

a. Discussion of Current Skills

This is where an acknowledgement of capacities and understandings should be illuminated, even if the outcome of the behavior or utilization of the skill set results in something the IDT does not agree with. Many individuals develop effective skills in the context of deprivation, rejection, and restriction; these skills should be given credit and described.

b. Focus on Communication and Social Skills

A description of skills in the context of communicating with others, whether it is to communicate a want or need, obtain a preferred item, or to express an opinion is an appropriate transition from the assessment to the plan.
If you do not know where to focus ideas for planning – START HERE.

c. Relationship to Challenging Behavior (i.e., Possible Replacement Behaviors)

This is a root of the Positive Support Plan. Some basic beginning ideas on how the person may ask for what they need or how staff can learn new skills to lessen the frequency and severity of the behavior. Staff can learn to read the 'build-up' to the behavior and intervene at an earlier stage. No need to get too detailed here – save it for the PBSP.

XI. EFFECTIVENESS INDICATOR: CHALLENGING BEHAVIOR

BSC work is not just about 'reducing the frequency of challenging behaviors'. It is about being a voice of advocacy and negotiation with/for the person you support. BSCs do this by making sure they look beyond behaviors towards the potential for increasing a person's sense of identity, purpose and meaning in their life.

Perhaps a better way to think of this is "Behaviors that Challenge Our System". The challenge is ours – to be better at creating a meaningful life for the person, to adjust the system, and to understand the communication underlying what we can observe. In many ways, a person's so-called challenging behavior may be functional – it serves a purpose – but may not be 'appropriate'. The job is not to 'squash' or eliminate the behavior as this does not address the <u>unmet need</u>. Odds are that the pattern will simply pop out again somewhere else in the person's life. By focusing on unmet needs and support rather than on numbers of occurrences and control we can take behavioral data and use it in a person-centered fashion.

That being said, it remains useful in certain situations to collect clear and objective behavioral data. The following is the method we use to compile a Functional Assessment.

Start by picking 1-3 'challenging behaviors' that the individual may demonstrate. Pick the ones that seem to be the biggest barriers to growth – that have a higher level of causing passible harm to the person or others or get in the way of the person leading the life they want to live. It is important to get clear feedback from staff and family about this: find out what the people most familiar with the individual see as the biggest challenges. If at all possible – always get the individual's input into this as well.

a. Description of Behavior(s)

A concrete, specific and detailed description of the behavior. Don't get into theories of why or how etc. Simply describe the behavior. The goal is to be clear enough that a person reading it would be able to fully act out the actions without ever seeing it.

b. Frequency

What is the best timeline by which to measure the behavior or pattern of concern? Hourly? Daily? Monthly? Annually? Are you hoping to count every single occurrence or just that it happened over the course of a day/week/month? The units and stipulations of measurement depend on the nature of the pattern of concern.

c. Severity

Simply state how severe the behavior is occurring over the few months preceding the assessment. If this is an update of an assessment try to include previous year's data as well as current. This could be measured using a continuum in terms of harm (e.g., gesture→fleeting mark→lasting bruise→onsite first aid→needs medical attention) or damage (e.g., monetary cost) or distance/time (e.g., for elopement). Sometimes this can be done using a Likert scale (e.g., Levels 1-5 of severity).

d. Antecedents

This answers the question: 'What makes it more likely that the behavior may occur?' These could be environmental factors, certain activities, weather, types of interaction to name a few. With the smoking example this would likely include items like, just had a meal; just went through a stressful meeting.

e. Precursors

This is the answer to the questions of 'how does the individual build-up to the above-described behavior?' or 'how do we know the behavior or pattern is about to occur?' For example – if the behavior was 'smoking a cigarette' the precursors could be: pats pack of cigarettes in pocket; pulls out pack; pulls out lighter; puts cigarette in mouth; flicks lighter; places flame of lighter to end of cigarette. Those more familiar with the person may even know of earlier precursors – like a certain look on the face, a type of deep breath, a change in tone of voice etc. Knowing the precursors can lead to prevention tactics versus intervention tactics – the difference between being proactive vs. reactive. There are times when behaviors occur without clear precursors or 'out-of-the-blue'. In fact, this is the answer you will get most often from staff, "I don't know – it just happens." While this may be true – do some more digging and you will usually find that there is a 'behavioral chain' of sorts that people didn't even know they knew. If possible – of course ask the client – "Do you know when you're going to do x? How do you know?"

f. Function(s)

For the most part, there are four possible functions of any behavior:

1. *Tangible: …to get an item.*
2. *Escape/Avoid: …to get away or avoid an event/activity/person/environment/ sensory experience.*
3. *Attention: …to gain the attention of someone specific or a specific type of attention.*
4. *Sensory: …to satisfy a sensory need e.g. self-regulation, de-stimulation, hunger, pain.*

PLEASE NOTE: Rarely can any behavior or pattern be pigeonholed into one function. This is a 'best-guess' endeavor that may be helped by asking the person, asking family or

direct support professionals, and listening to your gut. In a minority of cases, it may be worth it to do a more structured functional assessment using a tool such as the Functional Assessment Screening Tool (FAST) or Motivation Assessment Scale (Durand, 1997).

XII. EFFECTIVNESS INDICATOR: TEAM FACTORS

The BSC is responsible for assessing the IDT's current perspective and understanding regarding relationship, environmental, and activity issues. Team strengths reflecting perspectives, practices, and understandings the BSC believes are consistent with positive behavior support should be noted. Perceived team perspectives, practices, and understandings inconsistent with Positive Approaches should be identified. The needs are then addressed in the PBSP.

a. Current Understanding: person-centered, individual rights/dignity, protection from ANE, understanding ecological context of behavior

The goal of enhanced quality of life is founded on underlying values that are essential to positive approaches. The foundation values are:

1. *Supports and services are person-centered and rely on specialized and generic resources*
2. *Individual rights and dignity are respected and protected.*
3. *Individuals are protected from undue health and safety risks and are free from abuse, neglect, coercion, and exploitation.*
4. *Behavior is understood from a broad <u>ecological</u> context.*

b. Areas of Potential Improvement

The BSC contributes to the IDT's holistic understanding of the individual from a current and historical perspective that guides team planning and subsequent support. The individual's family and staff will have enhanced confidence and capacity for responding to challenging behavior as well. This is observed regardless of impact on traditional behavioral topographies. In this subsection, we try to address the questions of, "What can we as a team do better"? "How might we change our own behavior or responses <u>first?"</u>

XIII. DETERMINATION OF NEEDED BSC UNITS FOR ISP YEAR XXXX-XXXX

In this section the BSC must clearly present the case for how many BSC hours are being requested and potentially allocated. This is not meant to be a re-statement of the information contained in the main body of the PBSA but is a brief summation of relevant factors that are clearly supported by the information contained throughout the main body of the PBSA.

In years past, we used to use the Behavior Support Consultation Prior Approval Request form (BSCPAR) to itemize these variables. This form is still available and may help to organize your thoughts and/or calculations. Completion of the BSCPAR for units request is now <u>optional</u>.

a. Clinical Impressions

Briefly state in plain language (no clinical jargon) your overall impression of the person. This should include positive aspects who they are in the world and then a direct statement of the challenges they are facing. It may include a pointed statement of your estimate of the severity or seriousness of the behavioral challenges you described in earlier sections.

b. Clinical Necessity for BSC Services

The following are general statements that help to justify the use of Medicaid monies for BSC services and partially explain to the TPA the main reasons BSC is needed and at what level. You may pick one, more than one, or just the last one if Exclusion Criteria apply (explained below). Simply erase the item(s) that do not apply.

- **i.** Behavior of concern impacts individual's ability to retain a baseline level of independence, or, for children, the baseline level of independence is also related to the developmental period that the child has obtained. And/or
- **ii.** Behavior of concern interferes with quality of life. And/or
- **iii.** Behavior of concern involves a health and safety risk needing professional behavioral recommendations to establish a safety net. And/or
- **iv.** Recommended replacement behavior or skills require BSC to initiate and monitor implementation. And/or
- **v.** The Interdisciplinary Team (IDT), Direct Support Personnel (DSP), family and/or natural supports need specific training in at least one area related to the above. Or
- **vi.** Based upon the information I received or observed, there is no assessed current clinical necessity for BSC services at this time. See below for explanation:

c. **Exclusion Criteria**

In some cases, after careful holistic assessment of the person and their ecology, it may become clear that BSC services are not clinically indicated or necessary. For example, BSC cannot be authorized or recommended if the set of sought after changes to the person's skills, behavioral communication, or environment can be addressed <u>exclusively</u> through one or more of the following items. Simply pick one, more than one, leave only the last item if applicable, and erase the rest. Start with this statement:

Based upon the information I received and observed, it is my determination that the set of sought after changes to the person's skills, behavioral communication, or environment can be addressed exclusively through:

i. Participation in the Socialization and Sexuality Education course. And/or,
ii. Basic changes to routines, environment, or safe and better supported access to choices. And/or,
iii. Participation in individual or group therapy; or any other mental health or behavioral health services that are typically provided through the general behavioral health system (e.g., individual, group, or family therapy, or psychiatric assessment and medication management). And or,
iv. EPSDT or school-based programs (e.g., behavioral intervention plans, strategies and supports provided through the local education authority) are available and seen as capable to support the person. Or
v. Exclusion Criteria for BSC services do not apply at the current time.

d. **Clinical Complexity Considerations**

This is referred to as "Complexity Factor" in the BSCPAR if you are using that form for reference. Basically, the clinical situation for some individuals includes variables that may require additional service utilization by the BSC. These types of considerations are listed below.

Use the introductory statement below and then simply retain the items that apply and erase the rest in your final version of the PBSA.

The following individual-specific variables are currently present and will require additional BSC units to address and support:

i. There is the presence of a mental health diagnosis or severe behavioral or psychiatric condition that is not currently well-managed or severe (*SPECIFY*) and puts person at risk for reduced access to community, loss of affiliation, and/or increased likelihood of psychiatric hospitalization, criminal justice involvement, or exploitation and abuse. And/or

   Note: In a situation where you believe PRSC is indicated but is <u>not</u> being utilized, this consideration <u>may</u> apply. See PRSC section below for more explanation.

ii. The individual is experiencing psychiatric and/or psychotropic medication evaluation(s) requiring specialized data collection and analysis. And/or

iii. BSC services must be used to initiate and/or manage behavioral strategies requiring Human Rights Committee approval *(SPECIFY).* And/or

iv. Ongoing BSC support and associated DSP training is needed for specialized and essential instructions supporting focused skill building needs *(SPECIFY).* And/or

v. There has been a significant change in psychiatric or medical condition requiring BSC re-assessment, Positive Behavioral Support Plan (PBSP) development or revision, with associated DSP and/or family training and monitoring *(SPECIFY)*. And/or

   Note: Aspiration risk management is one type of situation that should be included in this category to address Comprehensive Aspiration Rick Management Plan (CARMP) requirements.

vi. There have been new safety issues identified (Specify) which will require BSC re-assessment, Positive Behavioral Support Plan (PBSP) development or revision, as well as additional DSP and or family training, and monitoring. OR

vii. Based upon the information received and observed, there are no Clinical Complexity Considerations that have been identified.

The number of additional BSC units requested based upon the above complexity factors depends on the relative intensity of concerns and/or combination of complexity factors.

In general, if complexity factors are present, it would be typical for a BSC to request between 18 and 86 units in this area.

e. Supported Living Category

In some circumstances the Supported Living Category may be influenced by behavior support considerations.

In this section, please state the individual's Supported Living Category and if any behavioral support considerations have influenced the determination of the category. You may need to call the Case Manager to confirm.

If a person is determined to require Category 4 Supported Living (Extraordinary Medical/Behavioral Support) please specify what particular support needs influenced

this determination. This may be somewhat of a repeat or crossover with the item(s) listed in the sections about Complexity Factors (above) or Preliminary Risk Screening (below).

The following may be used as guidelines for what to write in this section. Simply retain what apply and erase those that do not apply.

INDIVIDUAL receives Family Living supports and therefore this section does not apply.

INDIVIDUAL receives Customized In-Home Supports and therefore this section does not apply.

INDIVIDUAL receives Category 1 Supported Living Services.

INDIVIDUAL receives Category 2 Supported Living Services.

INDIVIDUAL receives Category 3 Supported Living Services.

INDIVIDUAL receives Category 4 Supported Living Services. This level of support was determined as necessary due to *(provide explanation).* In this case, there will need to be additional BSC units budgeted in order to achieve the level of DSP oversight and monitoring necessary to determine the implementation and efficacy of behavior support strategies.

f. Preliminary Risk Screening and Consultation

Preliminary Risk Screening and Consultation is a service offered to teams when a person in supports has or is demonstrating concerning sexual or possibly sexual behavior(s) that pose or have resulted in a risk of harm to self or others or other adverse events.

If a person is receiving PRSC services, the BSC will have some additional duties that require more units per ISP year. These include but may not be limited to, completion and/or updates of the Risk Management Plan, participation in PRSC meetings (at least one per year but some situations necessitate two or more meetings that last approximately 90 minutes each, compilation of specific behavioral tracking data, additional trainings for support persons, etc.). Therefore, participation in PRSC would justify a request for additional BSC units.

Typical amounts of units to add for BSC services if a person is participating in PRSC are:
80 – if it is the initial year of PRSC participation and a Risk Management Plan must be newly formulated
48 – if the person has been established in PRSC and the Risk Management Plan just needs updated.

In this section, state if the person is <u>currently</u> receiving Preliminary Risk Screening and Consultation (PRSC) services. You may also state if you believe the person <u>should</u> be receiving PRSC services but is not. If applicable, please specify <u>why</u> the person is not in PRSC (e.g., the person, guardian, or IDT has opted not to participate in PRSC, and a Decision Consultation Form has been submitted). If you believe the person should be

receiving PRSC services but for various reasons they are not, this does not justify requesting additional BSC units in this section. Such circumstances may be addressed in the Clinical Complexity Considerations section above. If applicable, simply state, "PRSC appears to be indicated but is not utilized at the time of this report. Therefore, no additional BSC units are requested in this area."

Of course, in many cases, there is no use of PRSC because there is no clinical need for that service (i.e., there has been no known report or observation of a concerning sexual or possibly sexual behavior that places the person or others at risk of harm or other adverse events). In these cases, simply state, "Based upon the provided and observed information, PRSC is not clinically indicated at the time of this report. Therefore, no additional BSC units are requested in this area."

g. Crisis Supports

Crisis Supports are provided on a short- to moderate-term basis for persons who are experiencing an acute and highly concerning behavioral or mental health situation that <u>BBS has determined</u> requires specialized residential supports. Only certain residential agencies are approved as Crisis Supports providers. If a person is receiving residential Crisis Supports, there is a requirement that the IDT meet on a frequent basis. Therefore, there is a functional need for additional BSC units to cover these meeting hours as well as the expectation that there will be a heightened use of BSC observation, training, and other duties. Just because a person is 'in crisis' in your or others' opinion, does not mean that they are receiving Crisis Supports or that additional BSC units should be requested. These types of situations may be covered in the items listed in the Clinical Complexity Considerations section above.

State here whether or not the person is receiving residential Crisis Supports at the time of PBSA submission. If they are, the following language may be useful, "Mr./Ms. XX is currently receiving residential Crisis Supports. Therefore, additional BSC units will be necessary to adequately address the associated administrative and clinical practice requirements." Or, simply state, "Mr./Ms. XX is <u>not</u> currently receiving residential Crisis Supports.

If a person you support is receiving Crisis Supports, it is typical for a BSC to request 40 additional units (up to 80 per year) during the time the person is in Crisis Supports.

XIV. SERVICE RECOMMENDATIONS AND UNITS REQUEST

There is currently not a set formula for how to determine the number of units a BSC should request. The BSCPAR form mentioned earlier may be helpful to serve as a guide for the number of units each factor or area described in section XII above may necessitate. Of course, individual-specific variables can influence these considerations. Consult with your agency director or BBS Regional Specialist at any time if needed.

At the time of this version of the PBSA Guide, there is not a set maximum amount of BSC units per ISP year. The following general guidelines may, however, help to frame your request:
Initial year of BSC service: 120-288 units – based on the general level of supports you believe the person may necessitate.

Plus Complexity Factor(s): Add between 18-86 BSC units.
Plus consideration of Category 4 monitoring needs: Additional units likely covered by Complexity Factors or PRS considerations.
Plus PRSC: Add between 48-80 BSC units.
Plus Crisis Supports: Add 40 for each iteration of Crisis Supports in a budget year.

Remember – the units you request are inclusive of the units for all billable document completion as well as all other BSC duties. An individual you determine should be budgeted for a markedly high amount of BSC units would likely be new to BSC services and have several of the complexity, crisis, and/or PRSC variables present at the time of PBSA completion.

It would be exceedingly rare for a person with none of these factors present to necessitate a request for a markedly high amount of BSC units to be added to their budget.

On the other end of the spectrum are individuals who demonstrate a documented need for BSC services but have been assessed to have no complexity, PRS, or Crisis Supports-related support needs. The generally accepted 'base' for BSC units sits around 72-173 BSC units per ISP year.

Complete one of the items below and erase the items that do not apply.

a. Based upon the combined clinical considerations above. Exclusion Criteria have been met and BSC services are not clinically indicated. The following other services should be sought:
    i. Trainings *(specify)*
    ii. Community Supports *(specify)*
    iii. Counseling Services *(specify)*
    iv. Relationship Classes

b. Based upon the combined clinical considerations above, I respectfully request a budget of XXX units for ISP year XXXX-XXXX.

BSC SIGNATURE **DATE**
WITH TITLE AND CREDENTIALS

BSC SUPERVISOR SIGNATURE (If BSC is not independently licensed)

WITH TITLE AND CREDENTIALS