GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Medical 1:1 Prescription Form for People Receiving Support through HCBS IDD Waiver

Directions for completing this form:

ALL SECTIONS OF THIS FORM MUST BE FILLED OUT
OR THE FORM WILL BE RETURNED

1. The person or his or her residential provider staff or service coordinator must complete the top portion of the form with the person's demographic information and staffing ratio.
2. The person's physician or advanced practice registered nurse must complete the remainder of this form and must provide the medical justification for the need for the person to have a medical 1:1. This must include the person's medical condition that warrants a medical 1:1, the anticipated length of time the person will require a medical 1:1, the duties the medical 1:1 will perform and either a fade plan for the elimination of the need for a medical 1:1 or justification as to why a fade plan is not clinically indicated.
3. This form must be signed by the person or his or her substitute decision-maker, indicating informed consent to the use of individualized medical staffing.
4. Submit this request form to the person's service coordinator.

To be completed by the person or support team member of the person for whom the medical 1:1 staff is being requested:

Person's Name: _____ DOB: _____

Current Address: _____

Residential Provider (if applicable): _____

Day Program Provider (If applicable): _____

Service Coordinator: _____

Current Staffing Ratio at Home:_____

Person Completing Request: _____ Date: _____

To be completed by the Physician or Advanced Practice Registered Nurse:

Medical condition that necessitates 1:1 staffing:

_____

Anticipated Length of Time for 1:1 staffing (***not to exceed 90 days/ order***): _____

Clinical Justification and Duties of 1:1
Include amount and frequency of intervention(s) to be received. You may attach additional paper, if needed.

_____

_____

_____

Recommended Fade Plan or Statement Regarding Titration Not Being Clinically Indicated
What condition must exist to decrease and/or discontinue the 1:1, if clinically indicated?

_____

_____

_____

Physician or APRN Signature:_____ Date:_____

Ordering Clinician Name and Title: _____

Informed Consent: The following items have been explained to me and I consent to the proposed medical staffing:

- ☐ The purpose and intended outcome of the individualized staffing.
- ☐ The risks and benefits of having individualized staffing.
- ☐ The risks of not having individualized staffing.
- ☐ That consent may be withheld or withdrawn at any time with no punitive action taken against the person.

_____ _____

Signature of Person Giving Informed Consent Date

Printed Name & Relationship to the Person: _____