DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00926 (02/2022)

STATE OF WISCONSIN
Wis. Stat. § 51.61(1)(i)
Wis. Admin. Code ch. DHS 94.10

APPLICATION FOR THE USE OF PROTECTIVE EQUIPMENT OR MECHANICAL RESTRAINT CLTS AND CCOP

This form must be completed to request approval for the use of protective equipment or mechanical restraints for participants in the Children's Long-Term Support (CLTS) Program or Children's Community Options Program (CCOP). 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 — Participant	Date of Birth	Type of Request ☐ New ☐ Review

Current Address — Participant	City	State	Zip Code

Participant's Applicable Target Group(s) (check all that apply): ☐ CLTS—DD ☐ CLTS—PD ☐ CLTS—MH

Name — Parent/Guardian	Phone — Parent/Guardian

Current Residence — Participant

☐ Personal/Family Residence *(Same address as above)*

☐ Licensed or Certified Facility, e.g., Adult Family Home, Foster Home, Level 5 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 — Provider/ Agency that will use the restrictive measure

Service Type	Service Frequency

Address — Provider/Agency			Phone
City	State	Zip Code	Fax Number

Email

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

Service Type and Frequency

Address — Provider/Agency			Phone
City	State	Zip Code	Fax Number

Email

County Waiver Agency Submitting This Request	Date Submitted

Contact Person/Support & Service Coordinator	Phone	Fax Number	Email

Address — County Waiver Agency	City	State	Zip Code

Definitions

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

Yes	No		
☐	☐	**Protective Equipment**	Protective equipment includes devices that do not restrict movement but do limit access to one’s body and are applied to any part of a child or youth’s body for the purpose of preventing tissue damage or other physical harm that may result from their behavior.
☐	☐	**Mechanical Restraints**	The use of a device within the environment or applied to any part of a child or youth’s body that restricts or prevents voluntary movement within the environment or normal use or functioning of the body or body part that cannot be easily removed by the child or youth and is above and beyond typical safety measures used for same aged peers.

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	Phone
Primary Physician			
Psychiatrist			

Psychologist / Therapist			
Neurologist			
Other			
Other			

Target Behavior

Please attach copy of current support plan or behavior support plan

Describe or attach the person's dangerous 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 positive behavior supports and prevention plans, level of supervision, or other environmental modifications. Attach the current support plan, OT and PT evaluations, physician orders, informed consent by the participant or guardian.

What is the need?

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

Risks and Benefits

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

Proposed Protective Equipment or Mechanical Restraint

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 item 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 Plan

Describe or attach the sequential process during which less restrictive measures will be used that precedes the use of protective equipment or mechanical restraint.

Training

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

Reduction and Elimination Plan for the Use of Protective Equipment or Mechanical Restraint

Describe or attach the plan for reducing and eventually eliminating the need for protective equipment or mechanical restraint. Include measurable benchmarks.

Support Plan Monitoring and Review of Approved Protective Equipment or Mechanical Restraint Usage

Describe or attach how the support plan and approved measure usage will be monitored, documented, and reviewed.

Individuals Having Input Into the Support Plan

Name	Relationship to Participant

Plan Review

Plan Reviewed By	Name	Signature	Date Reviewed
Parent /Participant (if over age 18 and not under guardianship*)			

Guardian, if applicable*			
Placing Agency*			
Provider Agency*			
Primary Physician**			
Behavior Consultant or Specialist			
Other			
Other			

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