###### DDS Behavioral Services Program (BSP)

###### Parent or Guardian Agreement

The DDS Behavioral Services Program (BSP) is an in-home program available to individuals ages 8 to 21 with intellectual disability who have been diagnosed with a serious and persistent mental disorder as defined in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders and as evidenced by a current psychological or psychiatric assessment. The disorder must result in the impairment of the individual which substantially interferes with, or limits, his or her functioning in family or community activities.

The Behavioral Services Program is NOT an entitlement program and funding for the program is only within available appropriations. This means that services and supports can only be provided if they are within DDS’s current budget allocation.

**Please initial the following statements if you understand and agree with them.**

1. I understand and agree that DDS BSP services are designed to teach my family how to better support my child during our family’s routines and activities. The goal, over time, is to decrease the amount of supports and services that are needed for my child and increase the skills of my family. \_\_\_\_\_\_ **Initials**

2. I understand that I am the legally liable relative for my child. I understand and agree that I may be responsible for repayment of a portion or all of the state funding received for my child’s DDS BSP services based on a formula established and billed by the Department of Social Services (DSS). \_\_\_\_\_\_ **Initials**

3. DDS BSP is not an entitlement program and is the payer of last resort. Therefore, I understand and agree thatif my child has a diagnosis of autism spectrum disorder (ASD) I will pursue coverage for services from my private insurance. If my child is on Medicaid (a.k.a. HUSKY, Title XIX) and has a diagnosis of ASD, I will contact Beacon Health Options at 1-877-552-8247 to obtain information and accept the services deemed appropriate for my child. \_\_\_\_\_\_ **Initials**

4. I understand and agree that if I currently have private insurance and my ability to keep it active changes, I will discuss this change with my DDS case manager as soon as possible. \_\_\_\_\_\_ **Initials**

5. I understand and agree that if my child is found eligible for DDS BSP I will be required to apply for and maintain active Medicaid coverage (a.k.a. HUSKY, Title XIX) and enroll in the DDS Home and Community-Based Services (HCBS) Waiver. I also understand and agree that it is my responsibility to submit Department of Social Services (DSS) applications and required supporting documentation to DSS within 30 days of receipt of BSP services. \_\_\_\_\_\_ **Initials**

6. I understand and agree that some of my child’s services and supports are required to take place within the family home during my child’s daily routine. I further understand and agree that it is expected that I shall fully participate in all of my child’s therapeutic and behavioral services. \_\_\_\_\_\_ **Initials**

1. I understand and agree that my child shall have a Behavioral Consultant, Behaviorist or Psychologist funded through private insurance, the Local Education Agency (LEA) (i.e., school system), Medicaid, or DDS BSP to develop necessary supports and services for my child, including a Behavior Support Plan. \_\_\_\_\_\_ **Initials**
2. I understand and agree that once my child’s Behavior Support Plan has been completed that my family and I will receive guidance to implement my child’s plan during his or her daily routine. \_\_\_\_\_\_ **Initials**
3. I understand and agree that it is my responsibility to participate in the review of my child’s Behavior Support Plan and any supporting data with the DDS case manager, the support provider and other BSP team members at least every six months. \_\_\_\_\_\_ **Initials**
4. I understand and agree that my child’s Level of Need (LON) Assessment and Individual Plan shall be reviewed with the case manager and BSP team members every six months to reassess the need for DDS BSP funding and services. \_\_\_\_\_\_ **Initials**
5. I understand and agree that it is my responsibility to notify my child’s DDS case manager regarding all of my child’s hospitalizations, out-of-home placements, and significant medical and behavioral changes.

\_\_\_\_\_\_ **Initials**

1. I understand and agree that if my child receives an individual budget to purchase services that, as the Employer of Record, I shall be responsible to review all expense reports and spend within my child’s allocation. If I over-spend the allocation, it is my responsibility to pay for the overage. \_\_\_\_\_\_ **Initials**
2. I understand and agree that if my child is placed by his or her Local Education Agency (LEA) (i.e., school system) or other entity in an out-of-home residential program, for which the LEA or other entity is paying the cost of both the educational and residential programs, then my child shall no longer be eligible for DDS BSP. \_\_\_\_\_\_ **Initials**
3. I understand and agree that for the purposes of processing my child’s DDS BSP application and for future program and planning purposes, DDS may request and receive any Department of Children and Families (DCF) investigation summaries that have been completed by DCF. These investigation summaries may be provided by DCF to DDS without the consent of the parent or guardian. \_\_\_\_\_\_ **Initials**

By my signature below I affirm that:

1. My child’s DDS case manager or the DDS Regional Helpline case manager has reviewed the entire DDS Behavioral Services Program Family Handbook and this Parent or Guardian Agreement with me;
2. I understand the purpose and the requirements of the DDS Behavioral Services Program; and
3. Non-compliance with the conditions of the DDS BSP Parent or Guardian Agreement may result in discontinuation of DDS BSP supports for my child.

Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DDS Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_