**PROGRAM REVIEW COMMITTEE**

**REQUEST FOR EXEMPTION FROM THE PRC REVIEW PROCESS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** Click or tap here to enter text. | **Date of Birth:** Click or tap here to enter text. | | **DDS #:** Click or tap here to enter text. |
| **Home Address:** Click or tap here to enter text. | | **Class Member  Yes No** | |
| **Agency Residential Supports:** Click or tap here to enter text. | | | |
| **Employer/Work Site:** Click or tap here to enter text. | | | |
| **Licensed Prescriber of Psychiatric Medications:** Click or tap here to enter text. | | | |
| **Behavioral Health Provider:** Click or tap here to enter text. | | | |
| **Case Manager:** Click or tap here to enter text. | | **Nurse:** Click or tap here to enter text. | |

**Please fill out and complete the first 3 pages of this document.**

**NOTE:** You must provide the last or most recent psychiatric medication prescriber note; nursing and behavioral quarterly review or 6-month review; current individual plan (IP) and date of next IP; and behavior support plan, if applicable. Attach extra pages if you need more room to answer any of these questions.

1. **GUARDIAN OR LEGAL REPRESENTATIVE STATUS**
2. I do not have a guardian, or other legal representative. I give consent for my own medical treatment. Yes No
3. If you have a guardian, is that person a  plenary (full) or  limited guardian?

If you have a limited guardian, what areas of your life does that guardian help you with?

Click or tap here to enter text.

1. If you have a legal representative, other than a guardian, does that person help you with medical decisions and treatment? Yes No
2. **CURRENT LIVING SITUATION & LEVEL OF SUPPORT**
3. I live in a  DDS-operated, licensed, or funded residence; or  private residence (my own home or my family’s home).
4. Do you receive DDS-funded individualized supports or services at home? Yes  No If yes, how many hours a day do staff work with you?

Click or tap here to enter text.

1. What type of supports or services do you receive from staff (i.e., what do you do together)?

Click or tap here to enter text.

1. **MEDICAL APPOINTMENTS**
2. Do you find it hard to remember your doctors’ names and what each doctor helps you with?

Yes No

1. Do you schedule or make your own medical appointments? Yes  No
2. Do you arrange your own transportation to medical appointments? Yes  No
3. Do you choose your own doctor, dentist, psychiatric medication prescriber, etc.? Yes No
4. Do you find it helpful to have someone at your medical appointments to help you understand and remember the information the doctor shared about your health and any follow up you need?

Yes No

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| --- | --- | --- |
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1. **TAKING MEDICATION**
2. Do you understand why you are supposed to take your medications? Yes No
3. Are you able to identify the symptoms or behaviors that your medications are prescribed to address?

Yes No If yes, describe how the medications help with your symptoms or behaviors?

Click or tap here to enter text.

1. Do you feel comfortable talking about your medications with your doctor or prescriber? Yes No
2. Do you need help taking your medications on time? Yes No
3. Do you need help with getting your medications refilled on time? Yes  No
4. Do you need help keeping track of your medications?  Yes  No If yes, what kind of help do you get now and what kind of help do you think you need?

Click or tap here to enter text.

1. Are you taking any medications that cause you problems?  Yes  No If yes, what are those medications and what are the problems that they cause?

Click or tap here to enter text.

**I manage my own health care and medications and do not want a DDS regional review committee involved in reviewing my medications. I am asking that any psychiatric medications prescribed to me by my licensed prescriber of psychiatric medications not be reviewed by the DDS Program Review Committee.**

**Signature of Person Requesting Exemption:** Click or tap here to enter text.

**Date:** Click or tap to enter a date.

**If applicable, Signature and Relationship of Person Helping to Complete this Form:**

Click or tap here to enter text.

**PLEASE COMPLETE THE TABLE BELOW WITH YOUR MEDICATION INFORMATION.**

**(Most of this information can be found on your medication containers.)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Total Daily**  **Dosage & Route** | **Proposed Dosage**  **Range** | **Prescriber Full Name & Specialty (i.e., PMHNP, PCP, Psychiatry)** | **Clinical Diagnosis**  **(ICD-10/DSM-5 Code) that Medication is Indicated to Treat** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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**Planning and Support Team (PST)**

1. Are any members of the Planning and Support Team aware of any cognitive or psychological difficulties that would conflict with this individual’s independent ability to follow through with his or her care?

Yes No If yes, what are those cognitive or psychological difficulties?

Click or tap here to enter text.

1. Is the individual’s medication regimen effective in addressing his or her current symptoms? Yes No
2. Is the individual’s medication regimen effective in addressing his or her targeted behaviors? Yes No
3. Does the individual’s behavior support plan include aversive procedures for safety reasons (i.e., anything which may be unpleasant, or cause discomfort such as physical isolation or restraints) based upon addressing targeted behaviors or symptoms? Yes  No
4. Does the behavioral data for the individual show improvement of symptoms or targeted behaviors that are in his or her behavior support plan? Click or tap here to enter text.
5. Please identify any of the individual’s past drug interactions. Click or tap here to enter text.
6. Have any members of the PST identified issues with polypharmacy and the individual’s medication regimen? Yes  No If yes, what efforts have been made to address this polypharmacy?

Click or tap here to enter text.

1. Is there a drug tapering plan for the individual? Yes  No If yes, please explain: Click or tap here to enter text.
2. Have any alternatives to medications been discussed with the PST or tried with the individual?

Yes  No If yes, describe these alternatives: Click or tap here to enter text.

**PST:  Agrees  Disagrees with the request for exemption and gives the following rationale for such:**

Click or tap here to enter text.

**Signature**: Click or tap here to enter text. **Date:** Click or tap to enter a date.

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**PRC Exemption Committee Review Outcome**

**The regional PRC exemption committee has reviewed the information presented by the individual and his or her Planning and Support Team (PST) and recommend that the request be:**

**Granted  Denied**

**Signature:** Click or tap here to enter text. **Date:** Click or tap to enter a date.

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**COMMENTS:** Click or tap here to enter text.

**I  Approve  Disapprove the request to be exempt from the PRC Review Process.**

If disapproved, the individual’s psychotropic medication will continue to require PRC review.

**Signature of Regional Director or Designee** Click or tap here to enter text.

**Date:** Click or tap to enter a date.

**COMMENTS:** Click or tap here to enter text.

**ANNUAL REVIEW OF PRC EXEMPTION BY PLANNING AND SUPPORT TEAM (PST)**

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**Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PST:  Agrees  Disagrees exemption remains appropriate**

**Case Manager Signature**: Click or tap here to enter text. **Date:** Click or tap to enter a date.

**Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PST:  Agrees  Disagrees exemption remains appropriate**

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**\*If no longer appropriate please contact your region’s PRC Liaison or PRC Exemption Committee chairperson**