

**JUSTIFICATION FOR DEVELOPMENTAL THERAPY & STEP DOWN
PLAN**

Date: ___/___/___

Consumer Name: _____ Record Number: _____
<input type="checkbox"/> Initial Request OR ___ Increase ___ Decrease ___ Continuation of current # hours
___ Current ___ Requested Dev.Th. (#hours per day/week) _____ If
continuation, how long has consumer been receiving services at this amount? _____
___ Current ___ Requested Dev. TH. Service Provider _____
Primary Clinician (<i>person completing this form</i>): _____

Why is service and intensity needed?

Describe main functional deficits:

What Client goals / needs will be the focus of Developmental Therapy Intervention?

What can be done to reduce hours/need for service? Check all that apply.

- Placement Change? Provider Change? Plan/Cost summary Adjustment? Increase natural supports?

Specify what is needed to ensure safety:

Additional Comments / **Requested Dev. TH. Provider Characteristics** / **Step-Down Plan:**

Please see contents of plan of care/treatment plan regarding specifics of step down plan.