DELAWARE HEALTH AND SOCIAL SERVICES Division of Developmental Disabilities Services	HRC RIGHTS REVIEW REQUEST FORM

SERVICE RECIPIENT'S NAME:	MCI NUMBER:
DATE OF BIRTH:	ANNUAL REVIEW DATE:
COUNTY OF RESIDENCE: ☐ Kent ☐ New Castle ☐ Sussex	NAME OF SUPPORT COORDINATOR/COMMUNITY NAVIGATOR:
NAME OF PERSON MAKING HRC REQUEST:	RELATIONSHIP TO SERVICE RECIPIENT:

PART I (required)	Background Information

Please explain why you are requesting a review by the HRC:

PART II (if applicable)	Human Rights Restrictions

Section 1	Restriction of Rights
RESTRICTION:	DESCRIPTION
	JUSTIFICATION
	PREVIOUS STRATEGIES TRIED
	RISK BENEFIT ANALYSIS
	PLAN TO FADE

RESTRICTION:	DESCRIPTION
	JUSTIFICATION
	PREVIOUS STRATEGIES TRIED
	RISK BENEFIT ANALYSIS

SERVICE RECIPIENT'S NAME:	MCI NUMBER:

	PLAN TO FADE

RESTRICTION:	**DESCRIPTION**
	JUSTIFICATION
	PREVIOUS STRATEGIES TRIED
	RISK BENEFIT ANALYSIS
	PLAN TO FADE

RESTRICTION:	**DESCRIPTION**
	JUSTIFICATION
	PREVIOUS STRATEGIES TRIED
	RISK BENEFIT ANALYSIS
	PLAN TO FADE

☐ DD/MM/YYYY
Date discussed with Support Coordinator/Community Navigator/Team

SERVICE RECIPIENT'S NAME:	MCI NUMBER:

PART III	Signatures & Consents

Section 1 Service Recipient's Signature

For those who are their own Legal Guardian:

By signing below, I acknowledge that I consent to the full contents of this rights restriction which may include the use of pharmacological interventions. An explanation of the rights restriction including the use of psychotropic drugs, any alternative procedures, possible benefits, side effects, and risks have been provided to me (verbally/written). This consent is given voluntarily and without coercion. I understand that I may withdraw my consent in writing at any time.

This consent automatically ends in one year, unless otherwise specified here (MM/DD/YY):

SERVICE RECIPIENT (please type the name of the person signing)

____

SERVICE RECIPIENT DATE

SERVICE RECIPIENT'S NAME:	MCI NUMBER:

Section 2	**Signatures for Legal Guardian or Supported Decision Maker**

For those who have a Legal Guardian:

By signing below, I acknowledge that I consent to the full contents of this rights restriction. An explanation of the rights restriction which may include the use of psychotropic drugs, any alternative procedures, possible benefits, side effects, and risks have been provided to me (verbally/written). This consent is given voluntarily and without coercion. I understand that I may withdraw my consent in writing at any time.

This consent automatically ends in one year, unless otherwise specified here (MM/DD/YY):

COURT APPOINTED GUARDIAN, AS APPROPRIATE (please type the name of the person signing)	COURT-ISSUED GUARDIAN NUMBER:

____

GUARDIAN DATE

SERVICE RECIPIENT'S NAME:	MCI NUMBER:

Section 3 Signature & Acknowledgement of DDDS Support Coordinator/Case Navigator

By signing below, I acknowledge that I have reviewed or someone has reviewed with me the full contents of this rights restriction.
SUPPORT COORDINATOR/COMMUNITY NAVIGATOR (please type the name of the person signing)
______________________________   SUPPORT COORDINATOR/COMMUNITY NAVIGATOR DATE

SERVICE RECIPIENT'S NAME:	MCI NUMBER:

PART IV	**HRC REVIEW**

HRC Comments and/or recommendations to the Team:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Date of HRC Presentation:	This Restriction of Rights will next be reviewed on or before:
FOR Rights Restrictions: ☐ Satisfactory ☐ Requires Additional Review _____ Number of votes _____Number of votes	____ HRC CHAIRPERSON OR DESIGNEE DATE