

The TSS Schedule Form for Prescriber/Family and ISPT Collaboration

Please include this form in the Recommendations Section of the Best Practice Evaluation/Re-evaluation

Member Name: _____ Date: _____

Prescriber: _____ MA Level Evaluator (if applicable): _____

Child/Family Member(s) involved in the TSS discussion: _____

TSS Service Request (please check one): Initial POC Continued Stay POC Amended POC Transfer POC

Day/Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7AM							
8AM							
9AM							
10AM							
11AM							
12PM							
1PM							
2PM							
3PM							
4PM							
5PM							
6PM							
7 PM							
8PM							
9PM							
Total TSS hrs/day							
Total TSS hrs/week							

- Please discuss the child and family's goals for recovery, resiliency and independence and how TSS can be used for the purpose of skill building/transfer to attain these.
- Please assure that the family and/or caretaker(s) are able to participate as guided by the tx plan with the goal of skill transfer for all prescribed TSS.

Time	Write in Day(s) Below on the first line and Activity and Behaviors/Symptoms/Focus of Treatment on the second line (please use to document activity and behaviors/symptoms which are a focus of treatment for TSS intervention during each day and time period on page 1 when additional space is needed) Note: Days and times for the same activity with the same focus may be documented together
	Day(s): Activity and behaviors/symptoms/treatment focus:
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