DEVELOPMENTAL COUNSELING FORM

For use of this form, see ATP 6-22.1; the proponent agency is TRADOC.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	5 USC 301, Departmental Regulations; 10 USC 3013, Secretary of the Army.
PRINCIPAL PURPOSE:	To assist leaders in conducting and recording counseling data pertaining to subordinates.
ROUTINE USES:	The DoD Blanket Routine Uses set forth at the beginning of the Army's compilation of systems or records notices also apply to this system.
DISCLOSURE:	Disclosure is voluntary.

PART I - ADMINISTRATIVE DATA

Name *(Last, First, MI)*	Rank/Grade	Date of Counseling

Organization	Name and Title of Counselor

PART II - BACKGROUND INFORMATION

Purpose of Counseling: *(Leader states the reason for the counseling, e.g. Performance/Professional or Event-Oriented counseling, and includes the leader's facts and observations prior to the counseling.)*

Event Oriented-
Special Compensation for Assistance with Activities of Daily Living (SCAADL) Eligibility/Ineligibility

PART III - SUMMARY OF COUNSELING

Complete this section during or immediately subsequent to counseling.

Key Points of Discussion:

SCAADL DISAPPROVAL:
I have reviewed your application/redetermination for SCAADL. Your application/redetermination is denied for the following reasons:
1.
2.

Your SCAADL benefits have been stopped as of _____.

SCAADL APPROVAL:
Your application for SCAADL is approved. Given that you live in Zip Code_____, and have been determined to need personal caregiver assistance at the Tier ____ level, you are eligible for monthly compensation of $_____. The effective start date for payment of this compensation is _____.

If approved you are reminded that you have a continuing requirement to designate a Primary caregiver to provide non-medical care, support and assistance with activities of daily living and to keep the caregiver's contact information updated with the command. Your primary caregiver may not be another military member. Failure to pay your caregiver may result in adverse administrative action. SCAADL payments are TAXABLE income.

Your eligibility for SCAADL expires on the earlier of the following:

(1) the last day of the month during which a 90-day period ends that begins on the date of your separation or retirement
(2) the last day of the month that the members death
(3) the last day of the month during which a licensed physician determines that you are no longer afflicted with the catastrophic injury or illness; no longer require hospitalization, nursing home care or other residential institutional care absent assistance; or no longer an outpatient. You are not entitled to SCAADL if you have not met with a physician but are no longer afflicted with a catastrophic illness or injury; no longer require hospitalization, nursing home care or other residential institutional care absent assistance; or no longer an outpatient; or
(4) the last day of the month preceding the month during which you begin receiving a monthly aid and attendance allowance from the VA.

I will determine your continued eligibility for SCAADL benefits and whether your level of benefits remains appropriate every 180 days, or earlier should your medical condition or circumstances, changes, or you relocate.

If you disagree with this decision for any reason, including your eligibility or the Tier level assigned to you, you may appeal. You must submit your appeal request to the Commander in writing within 60 days of denial notification, and you must submit a statement outlining the reason(s) for the appeal and all supporting documents pertaining to the original application for SCAADL to the Commander for further disposition. You appeal will then be forwarded to WCT Commander for final decision.

OTHER INSTRUCTIONS

This form will be destroyed upon: reassignment *(other than rehabilitative transfers)* , separation at ETS, or upon retirement. For separation requirements and notification of loss of benefits/consequences see local directives and AR 635-200.

Plan of Action *(Outlines actions that the subordinate will do after the counseling session to reach the agreed upon goal(s). The actions must be specific enough to modify or maintain the subordinate's behavior and include a specified time line for implementation and assessment (Part IV below)*

You or your (Designated representative) will keep the Chain of Command informed of all changes regarding your medical care

You or your (Designated representative)will keep the Chain of Command informed of all changes in location as they may affect the level of your benefits due to zip code changes

If you or your (Designated representative) have elected to appeal, you will follow the appellate process and submit it in writing through your Chain of Command

Session Closing: *(The leader summarizes the key points of the session and checks if the subordinate understands the plan of action. The subordinate agrees/disagrees and provides remarks if appropriate.)*

Individual counseled: ☐ I agree ☐ disagree with the information above.

Individual counseled remarks:

I plan to Appeal my DD2948 Tier Level YES/NO initals_____.

I plan to Appeal my SCAADL eligibility YES/NO initals_____.

I understand that SCAADL payments are TAXABLE income YES/NO initals_____.

I understand that a redetermination must be conducted every 180 days or earlier if something changes my medical condition or circumstances or I relocate. YES/NO initals_____.

Signature of Individual Counseled: _____ Date: _____

Leader Responsibilities: *(Leader's responsibilities in implementing the plan of action.)*

I am available to answer any questions you may have.

Signature of Counselor: _____ Date: _____

PART IV - ASSESSMENT OF THE PLAN OF ACTION

Assessment: *(Did the plan of action achieve the desired results? This section is completed by both the leader and the individual counseled and provides useful information for follow-up counseling.)*

Counselor: _____ Individual Counseled: _____ Date of Assessment: _____

Note: Both the counselor and the individual counseled should retain a record of the counseling.