Interagency Placement Exception Form

Prospective resident's first name: _____ Intended Placement date:_____

Name of Adult Care Home Operator:_____ License# & Classification:_____

Address of prospective home:_____

The prospective resident being considered for placement approval is: (choose all that apply)

( ) Child being served by Child Welfare;
( ) Child being served by Developmental Disabilities;
( ) Child remaining in a home being licensed for adult(s);
( ) Adult being served by Developmental Disabilities;
( ) Adult being served by Mental Health and Addictions;
( ) Adult being served by Aging & People with Disabilities;

Form Instructions: **The ACHP requires Operators to complete a safety assessment prior to accepting a placement from a contracting public agency outside of the licenser classification.** In addition, each residents' Case Manager must review the accuracy of the information provided by operator in relation to each residents' needs and risk factors. The case manager should also review the operator's plan to mitigate any identified risk factors. The operator will then forward the completed form to the Adult Care Home Program Licenser for the ACH (fax to 503-988-5722). **If there is a change in the condition of this resident the operator shall notify the Adult Care Home Program Licenser**

Multnomah County Administrative Rules:

MCAR 023-080-330*: When Operators have contracts with more than one public human service agency, including but not limited to the State of Oregon DHS Children Adults, and Families (CAF), Mental Health and Addiction Services Division (MHASD) or Seniors and People with Disabilities (SPD), the Operator shall obtain written permission from each contracting agency with clients already in the home before admitting new residents to the home; the Operator shall notify each contracting agency whose clients already are residents in the home at least five business days prior to admitting private pay residents.*

MCAR 023-080-335*: Operators shall have written approval from the ACHP and other appropriate contracting agencies before admitting any foster child into an adult care home.*

MCAR 023-041-155: *Operators shall care only for residents whose impairment levels are within the classification level and care certification of the home…*

MCAR 023-020-105 (18)*: Classification - the ACHP's determination during licensure of the level of care an adult care home may provide. The ACHP classifies adult care homes for populations served in Multnomah County by the following divisions: Aging & Disability Services (ADS), Developmental Disabilities Services (DDS), and Mental Health and Addiction Services Division(MHASD)...*

Instructions: The following matrix section should be completed by the Operator. The Operator must perform a though screening of the potential resident prior to completing this matrix. Answer yes or no to risk factors

AFH Resident's Initials: ⇩ Risk Factors: ⇨	Prospective Resident:	Resident 1:	Resident 2:	Resident 3:	Resident 4:
Gender & age					
Funding agency					
Case Manager's name, email address & phone number (legible please)					
Bedroom arrangement Private/Shared, list roommate.					
Ability to evacuate in less than 3 minutes (with or without help)					
Behavior Risks:					
Verbal (cursing at others, threats)					
Hitting, kicking, shoving					
Throws heavy objects or uses weapons					
Sexually inappropriate behavior					
Sexual aggression please specify - Adults, Teens or Children					
Fire setting and fascination risk:					
Other behavior risk:					
Self harm					
Wandering					
Substance abuse/seeking					

Fear or harm to animals					
Vulnerability risks:					
Ability to clearly communicate needs					
Ability to move away from risk/mobility					
Medically fragile					
Other vulnerability or special care need					
Staffing needs for this individual in the home (eg. 1:1, arms' reach, visual, hearing, general awareness):					

Please describe the skills you possess to meet the needs of the prospective resident (experience, training, other attributes):

Safety Plan:
If any safety or risk factor is identified above, please describe your plan to mitigate risk:

Describe how you are going to meet the staffing needs of all residents (Attach staffing plan):

Operator: Your signature below indicates that you understand that it is your responsibility to maintain the health and safety of all your residents, that the information you have provided in this form is complete and accurate, and that you will implement the safety plan that is approved by the Case Managers and your licenser.

ACH Operator Name: Phone Number: Signature:		

Case Managers: Please review the accuracy of the information provided by operator in relation to the needs and risk factors of the resident you case manage and indicate below whether you agree or disagree that the information provided about the resident is accurate and complete. In addition, please indicate below whether you agree or disagree that the operator's safety plan for your resident is appropriate.

This document may be returned to the operator as incomplete if any area is left blank.

Name	Agency	Date Signed
Resident 1 initials: Name of Case Manager: Phone number : **1. The information provided in relation to this resident is accurate.☐AGREE or ☐DISAGREE** **2. The Operator's safety plan for mitigating potential risks appears to be appropriate.☐AGREE or ☐DISAGREE** **Signature:**	DD: County☐ or Brokerage☐ MH☐ APD☐ Child welfare☐ Other☐:	
Resident 2 initials: Name of Case Manager: Phone number : **1. The information provided in relation to this resident is accurate. ☐AGREE or ☐DISAGREE** **2. The Operator's safety plan for mitigating potential risks appears to be appropriate. ☐AGREE or ☐DISAGREE** **Signature:**	DD: County☐ or Brokerage☐ MH☐ APD☐ Child Welfare☐ Other☐: _____	
Resident 3 initials : Name of Case Manager: Phone number : **1. The information provided in relation to this resident is accurate. ☐AGREE or ☐DISAGREE** **2. The Operator's safety plan for mitigating potential risks appears to be appropriate.☐AGREE or ☐DISAGREE** **Signature:**	DD: County☐ or Brokerage☐ MH☐ APD☐ Child Welfare☐ Other☐: _____	

Resident 4 initials: Name of Case Manager: Phone number : **1. The information provided in relation to this resident is accurate. ☐AGREE or ☐DISAGREE** **2. The Operator's safety plan for mitigating potential risks appears to be appropriate. ☐AGREE or ☐DISAGREE** **Signature:**	DD: County☐ or Brokerage☐ MH☐ APD☐ Child Welfare☐ Other☐: _____	
Prospective Resident initials: Name of Case Manager: Phone number : **1. The information provided in relation to this resident is accurate. ☐AGREE or ☐DISAGREE** **2. The Operator's safety plan for mitigating potential risks appears to be appropriate. ☐AGREE or ☐DISAGREE** **Signature**	DD: County☐ or Brokerage ☐ MH ☐ APD ☐ Child Welfare ☐ Other ☐: _____	

Lisenser: Please indicate below your decision relating to the Operator's Placement Exception Request.

ACHP licenser Name: Phone number **Placement Exception Request is ☐ Approved or ☐ Denied** **Signature:**	Reason for denial:

Additional Comments:

Appeals Rights: If you do not agree with the above decision you may request an Administrative Conference with Program Manager by calling 503-988-3000

Distribution: ☐**Original:** ACHP file; **Copies to:** ☐Initiating ☐Operator; ☐ACHP certification/licensing file; ☐Agency Contracting Agent or Specialist _____; ☐All involved agency case managers ☐#1 ☐#2 ☐#3 ☐#4. *Date sent:*_____ *By:*_____