Interagency Placement Exception Form

Form Instructions:

Operators: Multnomah County Administrative Rules Operators to complete a safety assessment and submit an exception request when considering a new resident whose services are funded from a contracting public agency outside of the license classification, or when considering a new placement when the home already has a resident in the home with an approved interagency exception.

- Complete a risk and vulnerability assessment for each current resident and the prospective new resident
- Identify the skills/training/experience the Operator and/or staff have to meet the needs of the resident whose needs are outside the license classification
- Describe a safety plan to mitigate any identified risks or vulnerabilities for all residents
- Submit a proposed staffing plan and describe how you will meet the staffing needs of all residents.

Case Managers/Service Coordinators/Residential Services Specialist/Legal Guardians: Each resident's Case Manager or Service Coordinator, and legal guardian must:

- Review the accuracy of the information provided by operator about the needs and risk/vulnerability factors for the person they serve.
- Review the operator's safety plan to mitigate any identified risk factors.
- Sign and document whether they agree or disagree with this interagency placement.

The operator will then forward the signed, completed form to their Licenser (fax to 503-988-5722).

Applicable 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).*

Prospective Resident Information

Prospective resident's first name: _____

Chosen/preferred name: _____ Pronouns: _____

Operator Name: _____ License #: _____ Classification: _____

Address of prospective home:_____ Intended Placement date:_____

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 Behavioral Health

☐ Adult being served by Aging & People with Disabilities

Instructions: The following section should be completed by the Operator. The **Operator** must perform a though screening of the prospective new resident **prior** to completing this matrix. Answer yes or no to all risk factors					
Resident Initials:	**Proposed New:**	**Resident 1:**	**Resident 2:**	**Resident 3:**	**Resident 4:**
Legal sex & age					
Population (APD, I/DD, MHA, Child Welfare)					
Case manager: Include name, email address & phone number					
Bedroom arrangement Private or Shared (if shared, ID 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:					
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). Attach additional pages if needed.
Safety Plan: If any safety or risk factor is identified above, please describe your plan to mitigate risk. Attach additional pages if needed.
Describe how you are going to meet the staffing needs of all residents. Also attach a proposed 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 (Printed) and Phone Number	Signature	Date

Case Managers/Service Coordinators/Residential Specialists/Legal Guardians:

- Please review the accuracy of the information provided by operator in relation to the needs and risk factors of the resident you case manage or provide services to.
- 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. ACHP relies on your knowledge of the resident's service needs, vulnerabilities and risks and your assessment of the plan to mitigate risk.

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

Prospective Resident initials: _____ Service (Funding) Agency:_____

Name of Case Manager: _____ Phone number: _____

1. The information provided in relation to this resident is accurate. ☐ **AGREE or** ☐ **DISAGREE**

2. The safety plan for mitigating potential risks appears to be appropriate. ☐ **AGREE or** ☐ **DISAGREE**

Signature: _____ Date signed: _____

Resident 1 initials: _____ Service (Funding) Agency:_____

Name of Case Manager: _____ Phone number: _____

1. The information provided in relation to this resident is accurate. ☐ **AGREE or** ☐ **DISAGREE**

2. The safety plan for mitigating potential risks appears to be appropriate. ☐ **AGREE or** ☐ **DISAGREE**

Signature: _____ Date signed: _____

Resident 2 initials: _____ Service (Funding) Agency:_____

Name of Case Manager: _____ Phone number: _____

1. The information provided in relation to this resident is accurate. ☐ **AGREE or** ☐ **DISAGREE**

2. The safety plan for mitigating potential risks appears to be appropriate. ☐ **AGREE or** ☐ **DISAGREE**

Signature: _____ Date signed: _____

Resident 3 initials: _____ Service (Funding) Agency:_____

Name of Case Manager: _____ Phone number: _____

1. The information provided in relation to this resident is accurate. ☐ **AGREE or** ☐ **DISAGREE**

2. The safety plan for mitigating potential risks appears to be appropriate. ☐ **AGREE or** ☐ **DISAGREE**

Signature: _____ Date signed: _____

Resident 4 initials: _____ Service (Funding) Agency:_____

Name of Case Manager: _____ Phone number: _____

1. The information provided in relation to this resident is accurate. ☐ **AGREE or** ☐ **DISAGREE**

2. The safety plan for mitigating potential risks appears to be appropriate. ☐ **AGREE or** ☐ **DISAGREE**

Signature: _____ Date signed: _____

Licenser: Please indicate below your decision relating to the Operator's Interagency Placement Exception Request for Prospective Resident _____ (initials).

ACHP Licenser Name: Phone number: **Signature:** **Date:**	**Operator Name:** **License #:** **Placement Exception Request is** ☐ **Approved or** ☐ **Denied** Reason for denial:

Additional testing, training or certifications: if approved, the following additional trainings, testing and/or certifications must be completed by the Operator, Resident Manager and all caregivers.

☐ Updated background Checks and role approvals for the new population

☐ Ensuring Quality Care Essentials to be completed by: _____

☐ Pre-service dementia training to be completed by: _____

☐ HCBS-IBL Training through Oregon Care Partners to be completed by:_____

☐ Providing Including Care Training through Oregon Care Partners to be completed by: _____

☐ APD Caregiver Workbook to be completed by: _____

☐ DD Basic Training and Qualifying Test to be completed by: _____

☐ Oregon Intervention System Certification to be completed by: _____

☐ Monthly training series provided by Multnomah County Behavioral Health Residential Specialists

☐ Other required training or testing(s) as follows:_____

☐ ____ hours of annual continuing education credit related to: _____

Future admissions: The Operator must complete this interagency placement exception prior to **all** future admissions while you continue to serve residents from multiple service agencies.

Changes in condition: If there is a change in the condition of any resident with an approved interagency placement, the operator shall notify the Adult Care Home Program Licenser.

Additional Licensing Comments or Requirements:

Appeal 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 ☐ New ☐ #1 ☐ #2 ☐ #3 ☐ #4.
*Date sent:*_____ *By:*_____