Print | Save | Reset

Individual Consent to HCBS Limitation(s)

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Date printed: _____ Individual's birthdate: _____

Individual's name: _____

Provider's name: _____ Private pay? Yes

Provider address: _____

Individually-Based Limitations to the Rules for individuals receiving Home and Community-Based Services (HCBS) in a provider-owned, controlled or operated residential setting:

This form is to be completed when there is an Individually-Based Limitation(s) to the HCBS rule requirements proposed in a provider-owned, controlled or operated residential setting. **Select the appropriate limitation(s) from the list below by providing the requested start and end dates for the limitation(s). These dates cannot exceed one (1) year.**

Rights that may be limited	Requested start date	Requested end date
Access to food at any time		
Choice of roommate in shared units		
Control own schedule and activities		
Freedom from restraint		
Furnish and decorate bedroom or living unit		
Privacy — Lockable doors		
Visitors at any time		

1. Describe the Individually-Based Limitation to the Rule. (*Who proposed this limitation? What is it? When is it implemented? How often? By whom? How is the limitation proportional to the risk?, etc.*)

2. Describe the reason/need for the Individually-Based Limitation, including assessment activities conducted to determine the need. (*What health or safety risk is being addressed? Assessment tool, outreach, consultation, etc.*)

Print | Save | Reset

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (*Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried, but which did not work, etc.*)

4. Describe how this Individually-Based Limitation is the most appropriate option and benefits the individual. (*Why/how does implementing the limitation make sense for the individual's personal situation?*)

5. Describe how the effectiveness of the Individually-Based Limitation will be measured. (*Including ongoing assessment and/or data collection and frequency of measurement.*)

6. Describe the plan for monitoring the safety, effectiveness, and continued need for the limitation. (*Who is responsible to monitor? How frequently? How is the ongoing need for continued use of the limitation to be determined? Etc.*)

Print | Save | Reset

Decision summary and signature section

Select appropriate limitation(s) below by including start and end dates, as applicable. Indicate whether the individual consents, or does not consent, to the limitation(s). Please request the individual, or legal representative/guardian (*if applicable*), initial each limitation to ensure the individual's wishes are accurately reflected.

I understand I am <u>not</u> required to consent to any proposed limitation(s).

Rights that may be limited	Start date	End date	Consent?	Individual's initials
Access to food at any time			○Yes ○No	
Choice of roommate in shared units			○Yes ○No	
Control own schedule and activities			○Yes ○No	
Freedom from restraint			○Yes ○No	
Furnish and decorate bedroom or living unit			○Yes ○No	
Privacy — Lockable doors			○Yes ○No	
Visitors at any time			○Yes ○No	

If the individual <u>does not</u> agree or consent to a limitation, it will <u>not</u> be put in place.

A copy of this document will be provided to the individual.

Individual statement

I have read the above information, or it has been provided to me in a format I can understand. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. Where Individually-Based Limitations were discussed, I was given additional options. It was made clear to me that I do not have to agree or consent to any limitations. I agree to the sharing of this information with my care team, when applicable.

Individual, or legal representative/guardian (*if applicable*), please review that your wishes to consent or **not to** consent are accurately captured in the box you have initialed, above. Then print your name, sign and date below.

_____
Print name

_____ _____
Signature Date signed

Print Save Reset

Feedback from the individual:

Statement by the person centered service plan coordinator or witness

I have accurately read the information to the above named individual, and to the best of my ability made sure that the individual understands the documented Individually-Based Limitation(s).

I confirm that the individual was given an opportunity to ask questions about the Individually-Based Limitation(s), and all the questions have been answered accurately and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and when consent has been given, it is done freely and voluntarily.

APD/AAA case manager or private-pay witness, please sign and date below:

Print name _____ Phone number _____

Signature _____ Date signed _____

Check the appropriate box for your role:

○ APD/AAA case manager ○ Private-pay witness

You can get this document in other languages, large print, braille or a format you prefer. Contact APD Medicaid Services and Supports Team at 503-945-6412 or email hcbs.oregon@dhsoha.state.or.us. We accept all relay calls or you can dial 711.