DHS
Oregon Department of Human Services
Office of Developmental Disabilities Services

Individual Consent to HCBS Limitations

Individual's name: **Medicaid - Prime ID #:**
Setting: ☐ **In-home or Licensed setting provider's name:**
Individual's address:

Individually-based Limitations to the Rules (IBLs) for individuals receiving home and community-based services (HCBS)

Select the limitation from the list below. Provide the start and end dates for the limitation. ***(End date must not exceed one year from start date).***

IBLs for individuals requiring restraints in <u>any</u> setting.

IBL proposed for restraints in <u>any</u> setting	**Start date**	**End date**
Safeguarding Interventions		
Safeguarding Equipment that meets the threshold of restraint		

IBLs for HCBS <u>residential</u> setting requirements for individuals residing in a provider-owned, controlled or operated <u>residential</u> settings.

Residential Individually-Based Limitation proposed	**Start date**	**End date**
Access to personal food at any time		
Choice of bedroom roommate		
Control of own schedule and activities		
Furnish and decorate bedroom or living unit		
Lockable bedroom 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 <u>*current, specific*</u> reason/need for the individually-based limitation, including assessment activities conducted to determine the need.** *(What current*

health or safety risk is being addressed? Assessment tool, outreach, consultation, etc.):

3) **Describe what has already been tried and other possible options that were ruled out.** *(Include documentation of positive interventions used before the limitation; documentation of less intrusive methods tried, but did not work, etc.)***:**

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

5) **Describe how the effectiveness of this 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.)***:**

Frequency of monitoring:

☐ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annually ☐ Other:

How will the monitoring take place? *(Where, how and by whom will the monitoring occur?):*

Services Coordinator/Brokerage Personal Agent:

Provider:

Other:

Individual statement

I understand I am not required to consent to any proposed limitation. 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 and any questions that I have asked have been answered to my satisfaction. I agree to the sharing of this information with my care team, when applicable.

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Individual, or if applicable, guardian, print your name, sign and date below to consent.

Signature: _____ Date: _____
Name: _____
Consenting party: ☐ Individual ☐ Guardian

Feedback from the individual (*include details if the individual does not consent*):
_____
_____
_____
_____

Statement by the Services Coordinator or Brokerage Personal Agent

I have accurately read the information to the above named individual, and to the best of my ability, have supported the individual in understanding the documented Individually-Based Limitation.
I confirm that the individual was given an opportunity to ask questions about the Individually-Based Limitation, and all the questions have been answered accurately and to the best of my ability.. I confirm the proposed Individually-Based Limitations are intended to be non-aversive and pose the least risk of harm to the individual.

Services Coordinator/Brokerage Personal Agent, please sign and date below:
Print name: _____ Signature: _____
Phone number: _____ Signature date: _____

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

Copies provided to:
Individual: Date:
Guardian (if applicable): Date:
Service Provider(s): Date:

*The use of safeguarding interventions and safeguarding equipment that meets the threshold of restraint must be directed by a physician or other qualified practitioner through an order, medical plan, or Positive Behavior Support Plan, to ensure that the identified restraints pose the least risk of harm to the individual.