Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Aging and People with Disabilities (APD), Home and Community-Based Services (HCBS) and Settings, Individually-Based Limitation (IBL) Alternative to Process Flowchart

Chart 1 – Individual (Legal Representative/Other Designee) is able to consent*

See “Terminology” page at the end of the document for explanation of acronyms and terms.

First, the provider determines an IBL may be needed.

Next, the provider completes the APD 0556 questions to determine if an IBL is justified. If it is not justified, no IBL will be implemented. If the IBL is justified, the provider needs to determine if the individual pays privately for services or receives Medicaid.

The process for those who pay privately is:

1. The provider sends** the completed APD 0556 to HCBS Oregon
2. The IBL is reviewed to ensure it is appropriate and complete. Then it is returned to the Provider with suggestions, if any
3. If the IBL is not appropriate and complete, the IBL cannot be implemented. If the IBL is appropriate and complete, the provider meets with the resident, their representative and/or a private-pay witness
4. If consent is not given to the IBL, the IBL cannot be implemented. If consent is given to the IBL, it may be implemented
5. Upon implementation, the provider updates the individual’s care plan and keeps a copy of the signed APD 0556 on file.

The process for those who receive Medicaid is:

1. The provider sends the completed APD 0556 to the Medicaid Case Manager
2. The Case Manager reviews the IBL request to determine if it is appropriate and complete.
3. If the IBL is not appropriate and complete, the IBL cannot be implemented. If the IBL is appropriate and complete, the provider meets with the resident and/or their representative to obtain consent to the IBL
4. If consent is not given to the IBL, the IBL cannot be implemented. If consent is given to the IBL, it may be implemented
5. Upon implementation, the Case Manager updates the service plan, then distributes copies to the provider and the Medicaid file. The provider updates the individual's care plan and keeps a copy of the signed APD 0556 and service plan on file.

***If individual is unable to consent to IBL, use Chart 2**

****Temporary Change in private pay process**

Chart 2 – Individual is unable to consent* and has no one who can assist

See "Terminology" page at the end of the document for explanation of acronyms and terms.

First, the provider determines an IBL may be needed.

Next, the provider completes the APD 0556 questions to determine if an IBL is justified. If it is not justified, no IBL will be implemented. If the IBL is justified, provider must obtain a statement from the individual's Qualified Healthcare Provider (QHP) that states the individual is unable to consent to the IBL.

If the provider is unable to obtain a statement from the QHP, the IBL cannot be implemented. If the provider is able to obtain the statement from the QHP, the provider needs to determine if the individual pays privately for services or receives Medicaid.

The process for those who pay privately is:

1. The provider notes “Unable to Consent” on the completed APD 0556 and sends** it, with the QHP statement that the individual is unable to consent, to HCBS Oregon for review
2. The IBL is reviewed to ensure it is appropriate and complete. Then it is returned to the Provider with suggestions, if any
3. If the IBL is not appropriate and complete, the IBL cannot be implemented
4. If the IBL is appropriate and complete, the IBL may be implemented
5. Upon implementation, the provider updates the individual’s care plan and keeps a copy of the signed APD 0556 and QHP statement on file

The process for those who receive Medicaid is:

1. The provider sends the completed APD 0556, with the QHP statement that the individual is unable to consent, to the Medicaid Case Manager
2. The Case Manager reviews the IBL request to determine if it is appropriate and complete.
3. If the IBL is not appropriate and complete, the IBL cannot be implemented. If the IBL is appropriate and complete, the IBL may be implemented
4. Upon implementation, the Case Manager updates the service plan and the APD 0556, noting that the individual is “Unable to Consent” to the IBL. The Case Manager then distributes copies to the provider and the Medicaid file. The provider updates the individual’s care plan and keeps a copy of the signed APD 0556, QHP statement and service plan on file.

***If individual is able to consent to IBL, use Chart 1**

****Temporary Change in private pay process**

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Chart 3 – Individual revokes consent to IBL

See “Terminology” page at the end of the document for explanation of acronyms and terms.

First, the individual tells the provider they have revoked consent to the IBL. The IBL is no longer in effect. The notification does not have to be in writing.

Next, the provider notes “Revoked on [date]” (using the date of the revocation) on the existing/signed IBL (APD 0556). The provider has the individual sign and date the IBL form underneath the “Revoked on” area.

Then the provider needs to determine if the individual pays privately for services or receives Medicaid.

The process for those who pay privately is:

1. The provider updates the individual’s care plan.
2. The provider then determines how to mitigate the risk to the health and safety of the individual and others.

The process for those who receive Medicaid is:

1. The provider notifies the Medicaid Case Manager that the IBL is revoked.
2. The Case Manager updates the individual’s service plan agreement (SPA), noting the individual has revoked consent to the IBL.
3. The Case Manager distributes copies of the updated SPA to the individual, provider and Medicaid file.
4. The provider updates the individual’s care plan and keeps a copy of the updated SPA on file.
5. The provider then determines how to mitigate the risk to the health and safety of the individual and others.

Terminology

APD 0556 is the Individual Consent to HCBS Limitation(s) form (also called “IBL form”)

Care Plan means the person-centered plan of care developed by the provider for their resident

CM means Medicaid Case Manager

HCBS means Home and Community-Based Services

HCBS Oregon means the State’s shared email box where HCBS questions and IBLs may be sent: hcbs.oregon@odhsoha.oregon.gov

IBL means Individually Based Limitation to one or more of the following HCBS freedoms, rights

and protections [*refer to OAR 411-004-0020, section (1)(d) and (2)*]:

- Access to food at any time
- Control of own schedule/activities
- Decorate and furnish one’s bedroom/living unit
- Freedom from coercion and restraint
- Privacy in bedroom/living unit (i.e., lock on bedroom door/entrance door to unit)
- Roommate choice in a shared unit
- Visitors of own choosing at any time

QHP (Qualified Healthcare Professional) (Physician, Physician’s Assistant, Nurse Practitioner,

Qualified Mental Health Professional, or Psychiatrist) who knows the individual, who does not work at the individual’s care home/facility, and who makes the determination on whether the individual can consent to the IBL (i.e., make this long-term care decision). *(This is not a determination of the individual’s cognitive ability.)*

Service Plan refers to the person-centered service plan developed for Medicaid eligible individuals by their case manager, service coordinator, personal agent or other person designated by ODHS or OHA to provide case management services or person-centered service planning for and with individuals

Temporary Change (4/5/24-until further notice) refers to the new process where the provider submits the completed APD 0556 to HCBS Oregon for review. The need for continuation of this process will be redetermined at a later date

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Definitions

Is the IBL appropriate?

Yes, if there is a moderate health or safety risk to this individual or others.

Is the IBL complete?

The proposed IBL [APD 0556] must:

- Identify a defined and specific, individualized need
- Include less restrictive methods tried that failed
- Be directly proportionate to the specific, assessed need (and not be for the convenience of the provider)
- Describe how the effectiveness will be measured, and who will monitor the effectiveness
- Have a time limit (no more than 1 year)
- Be signed by the individual (or their designated representative)