Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

Instructions for completing the ODDS Hour Allocation and Staffing Ratio Exceptions Request

The ODDS In-Home Services Exception Request Smartsheet form (https://app.smartsheet.com/b/form/ae5c6222a71843478064dcff5247119f) is intended for Hour Allocation and Staffing Ratio exception requests that meet the exception criteria rule outlined in OAR 411-450-0065. For all other requests please use the ODDS 0514 form.

Who can complete the request?

An individual (or their representative) may request an exception. The request may come directly from the individual or the individual may be supported by the Services Coordinator(SC) or Brokerage Personal Agent(PA) to complete the form and submit the request on the individual's behalf. Individuals can request an exception from ODDS directly using this form https://www.oregon.gov/odhs/idd/Documents/individual-request-exception-en.docx , ODDS will contact the Case Management Entity(CME) and the SC or PA will be included in the process and will be expected to complete the exception request to address the individual's request.

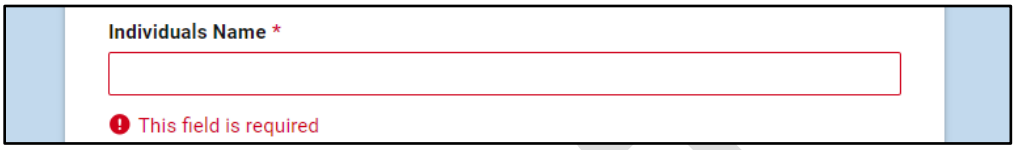
How to Complete a Request:

- Requests should be made using the In-Home Services Exception Request Smartsheet form. It can be accessed at this link. https://app.smartsheet.com/b/form/ae5c6222a71843478064dcff5247119f

- The In-Home Services Exceptions request form uses logic and skip patterns, this means that the order and type of questions that populate to the form are dependent on the answers given. Please select all of the options that apply.
    - If you have a question about which response to select, you can contact the ODDS.FundingReview@odhsoha.oregon.gov for assistance.

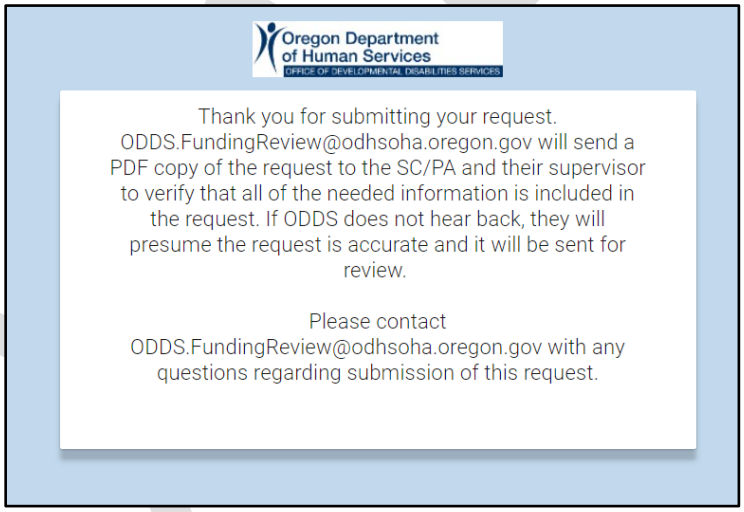
- Narrative responses should be clear and concise, with information related to *the specific question*. Responses should focus on *the support needs of the individual,* not the needs of the provider. DO NOT cut and paste the same answer for multiple questions.

- Questions with a red *** asterisk** indicate that the question is required to be answered to submit the form.



What happens after a request is submitted?

Once the request has been submitted a message will pop up on the screen indicating that ODDS has been notified of your request submission.



ODDS will send a PDF copy of the request to the SC/PA and their supervisor to verify that all of the needed information is included in the request, a response is only needed by the CME if additional information needs to be included. The request will be reviewed within the next 2 weeks and if additional documentation is needed a Notice of Pending Status (form 2853) will be sent to the individual and SC/PA within 10 business days.

Documentation: When reviewing an exception request, ODDS will review documentation to ensure that what is being requested aligns with documented support needs, unless otherwise indicated on the request. (note: it is not necessary to attach a copy of the Oregon Needs Assessment to this request).

Requesting Additional Information: When additional information is needed to make a final determination, ODDS will issue a Notification of Pending Status (NOPS) form (2853) within 10 business days of receiving the request. The NOPS will be sent via email to the SC/PA and the individual/legal guardian, it will be USPS mailed if an email address isn't available.

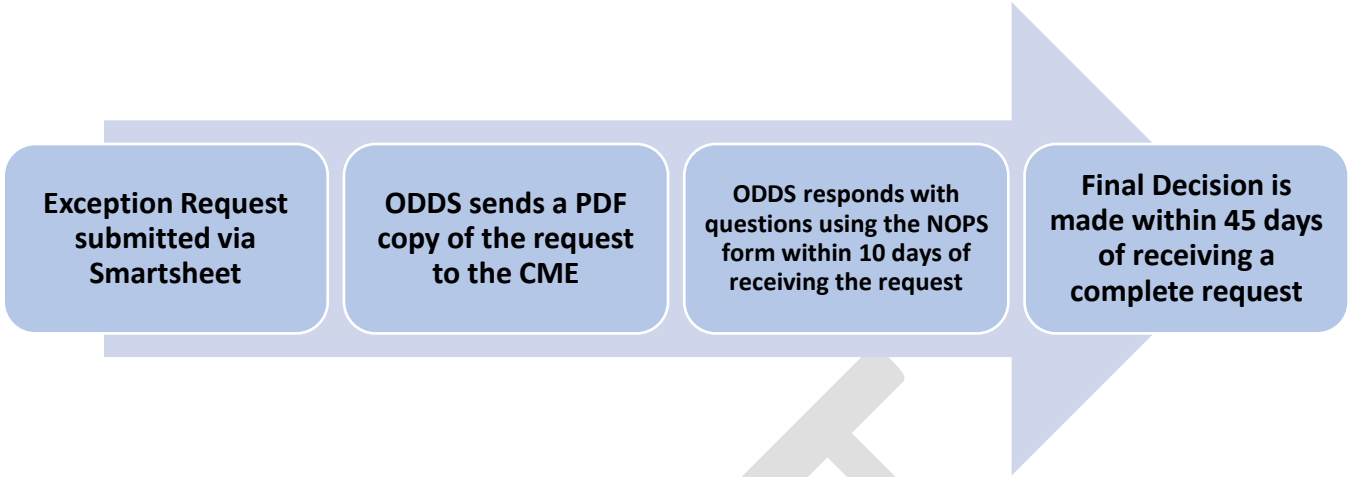
The NOPS will identify what additional information/documentation is needed; and will allow 14 calendar days to submit the requested information, it will also include a date the requested information is due. The additional information may be submitted to the ODDS.FundingReview@odhsoha.oregon.gov.

If ODDS does not receive the requested information by the identified due date, they will proceed to make a final determination based on the information they currently have. If the CME or individual submits the required documentation after the request has been denied, a new request submission is required.

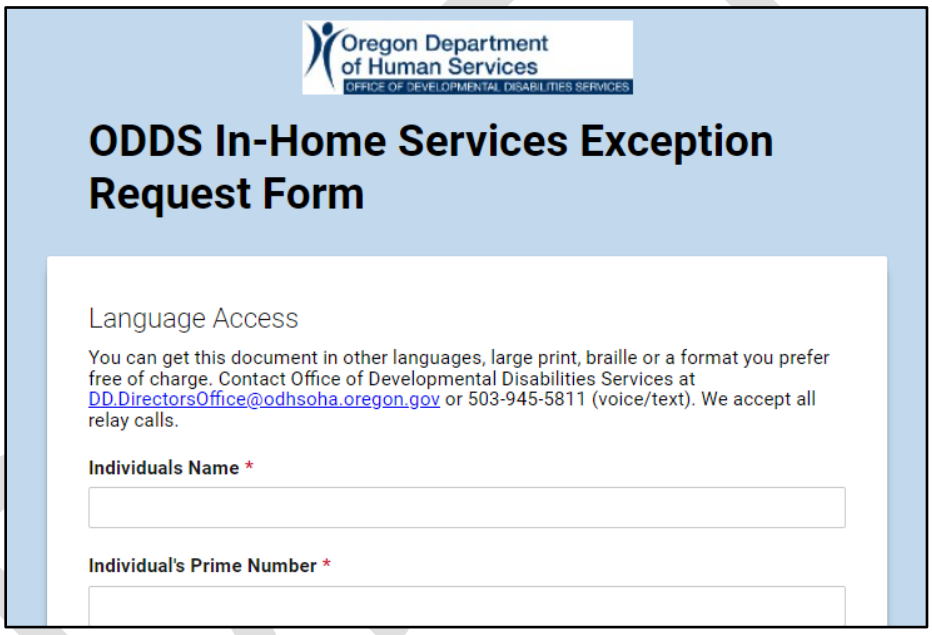
The individual may request a good cause extension prior to the expiration of the 14-day calendar day timeframe (date indicated on NOPS) via their case manager. If a good clause exception is requested by the individual, the case manager should notify ODDS.

*Note: Good cause exists when an action, delay, or failure to act arises from an excusable mistake or from factors beyond an individual's reasonable control.

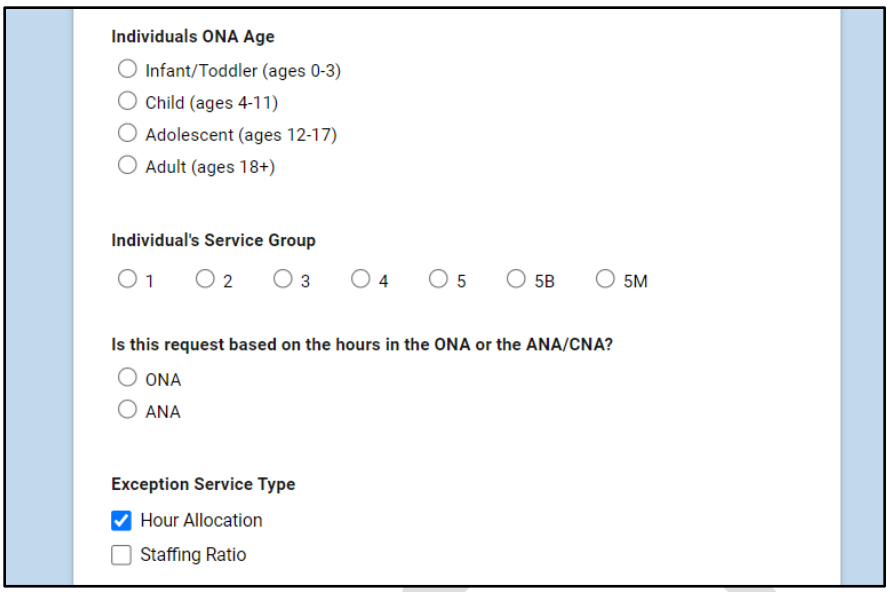
Final Determination Once ODDS has a complete exception request, they will make a final determination within 45 days. ODDS will email the final determination memo to the SC/PA and the SC/PA supervisor, it will also be uploaded into eXPRS and attached to the individuals Plan of Care (unless noted otherwise on the memo).



Completing ODDS Hour Allocation and Staffing Ratio Exceptions Request



Demographic and Contact Information: Answer all demographic and contact information. Contact information will be used when making decision notifications and should be accurate.



ONA Age: Answer this question based on the age that the individual was at the time of assessment.

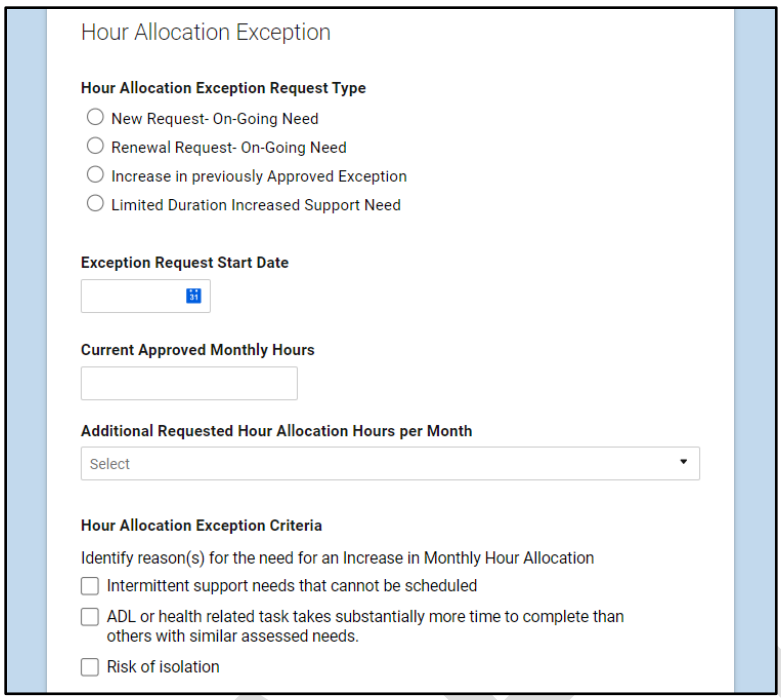
Children's Support Needs: For a child, identify and document how the request is for support is beyond that which a parent or guardian would provide for another child of the same age (Note this question will only open for those with an ONA age that is under 18).

Individual's Service Group: The individual's Service Group is the score generated by the Oregon Needs Assessment (ONA).

Is this request based on the hours in the ONA or the ANA/CNA? Identify which assessment the person is utilizing to determine their staffing level hours.

Exception Service Type: Select the type of exception being requested. Select both if an exception is needed for Hour Allocations and Staffing Ratio.

Hour Allocation Exceptions



Hour Allocation Request Type: Identify whether it is a new request, renewal request, increase from a previously approved exception or if the support need is time-limited.

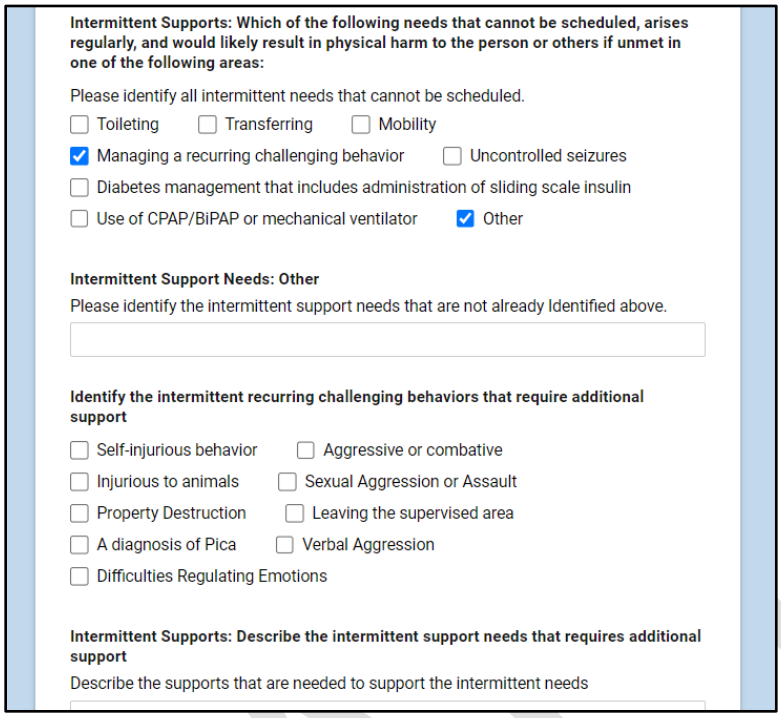
***Note**: Exception start and end date will only open if the exception type is limited duration. If approved, exceptions will begin on the date of the memo and will end in 3 years for children and 5 years for adults or if a certified assessor completes an assessment and the SG goes up or down.

Current Approved Monthly Hours: Identify the hours that are currently approved in the ISP.

Additional Requested Hours: Select the drop-down amount if additional hours are being requested. Hour amounts are in increments of 30. The number of total hours requested should not equal more than 744 hours/month (approvals will not exceed 744).

Hour Allocation Exception Criteria: Identify all the support areas requiring additional hours a month.

Hour Allocation: Intermittent Support Needs



Intermittent Supports: Which of the following needs that cannot be scheduled, arises regularly, and would likely result in physical harm to the person or others if unmet in one of the following areas:

Please identify all intermittent needs that cannot be scheduled.

- [ ] Toileting
- [ ] Transferring
- [ ] Mobility
- [x] Managing a recurring challenging behavior
- [ ] Uncontrolled seizures
- [ ] Diabetes management that includes administration of sliding scale insulin
- [ ] Use of CPAP/BiPAP or mechanical ventilator
- [x] Other

Intermittent Support Needs: Other

Please identify the intermittent support needs that are not already Identified above.

Identify the intermittent recurring challenging behaviors that require additional support

- [ ] Self-injurious behavior
- [ ] Aggressive or combative
- [ ] Injurious to animals
- [ ] Sexual Aggression or Assault
- [ ] Property Destruction
- [ ] Leaving the supervised area
- [ ] A diagnosis of Pica
- [ ] Verbal Aggression
- [ ] Difficulties Regulating Emotions

Intermittent Supports: Describe the intermittent support needs that requires additional support

Describe the supports that are needed to support the intermittent needs

Intermittent Supports: Identify all of the areas that require intermittent support. Failure to idenitfy all intermittent support needs may result in incorrect form logic.

- **Intermittent Support Needs: Other** If “Other” is marked, describe what other intermittent supports the individual requires.

Identify the intermittent recurring challenging behaviors that require additional support: Identify all recurring challenging behavior that have required additional support in the last year.

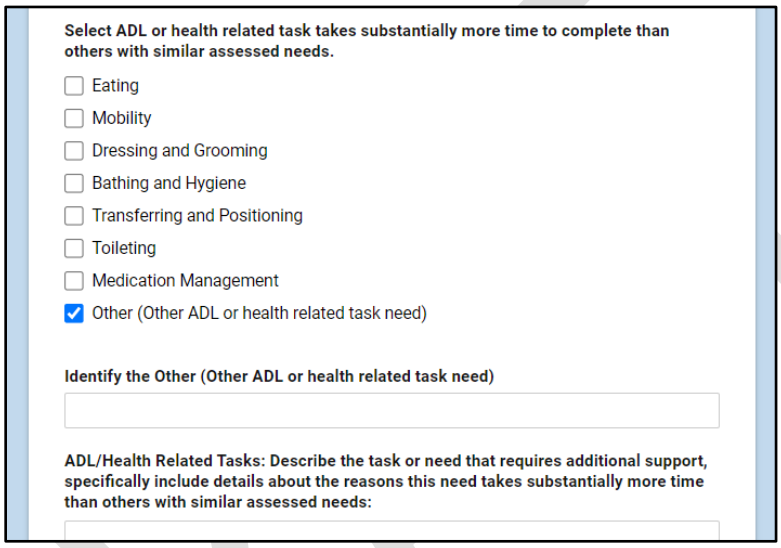
Intermittent Supports: Describe the intermittent support needs that requires additional support: Provide a summary of the individual’s intermittent support needs and describe why their current level of assessed attendant care hours is insufficient. Describe the supports that are needed to support this need. These exceptional support needs should align with the supports described in the individual’s supporting documents and the answers and notes indicated in the individual’s ONA.

How often in occurrences per week does this need arise? Identify the average number of occurrences per week that the intermittent support need arises.

How much time does it take to meet this need in hours per week? Identify how many hours a week are needed to support the person's intermittent support needs.

What are the consequences that are reasonably expected if the need is unmet? Describe the consequences that are reasonably expected if the hours are not approved. Identify the consequences that have occurred or could occur if this support need is not met.

Hour Allocation: ADL or Health Related Task



ADL/Health Related Tasks: Select ADL or health-related task takes substantially more time to complete than others with similar assessed needs. Identify all of the ADL/health-related tasks. Failure to identify all ADL/health-related support needs may result in incorrect form logic.

- **Identify the Other (Other ADL or health-related task need):** If "Other" is marked, describe what other ADL or health-related supports the individual requires.

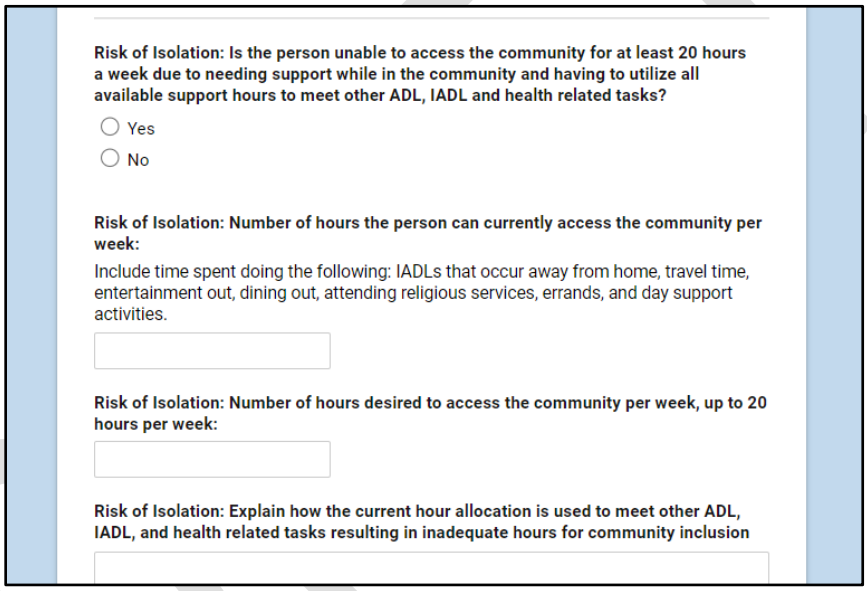
ADL/Health-Related Tasks Supports: Provide a summary of the individual's ADL/Health-related support needs and why their current level of assessed attendant care hours is insufficient. Describe the supports that are needed to support this need. These exceptional support needs should match the supports described in the individual's supporting documents and the answers and notes indicated in the individual's ONA.

How often in occurrences per week does this need arise? Identify the average number of occurrences per week that the *ADL or health-related* support need arises.

How much time does it take to meet this need in hours per week? Identify how many hours a week are needed to support the person's *ADL or health-related* support needs.

What are the consequences that are reasonably expected if the need is unmet? Describe the consequences that are reasonably expected if the hours are not approved. Identify the consequences that have occurred or could occur if this support need is not met.

Hour Allocation: Risk of Isolation



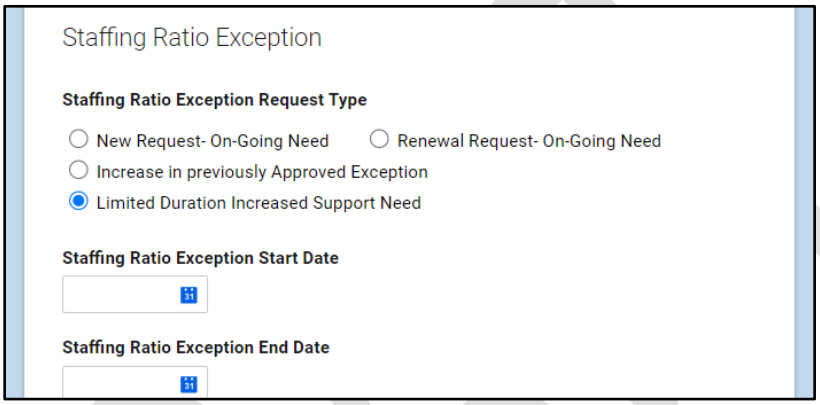
Risk of Isolation: Is the person unable to access the community for at least 20 hours a week If the individual is currently accessing the community for at least 20- hours per week, then select No.

Risk of Isolation: Number of hours the person can currently access the community per week: Identify the average number of hours the individual is currently accessing the community per week.

Risk of Isolation: Number of hours desired to access the community per week, up to 20 hours per week: Identify how many hours are needed to access the community per week?

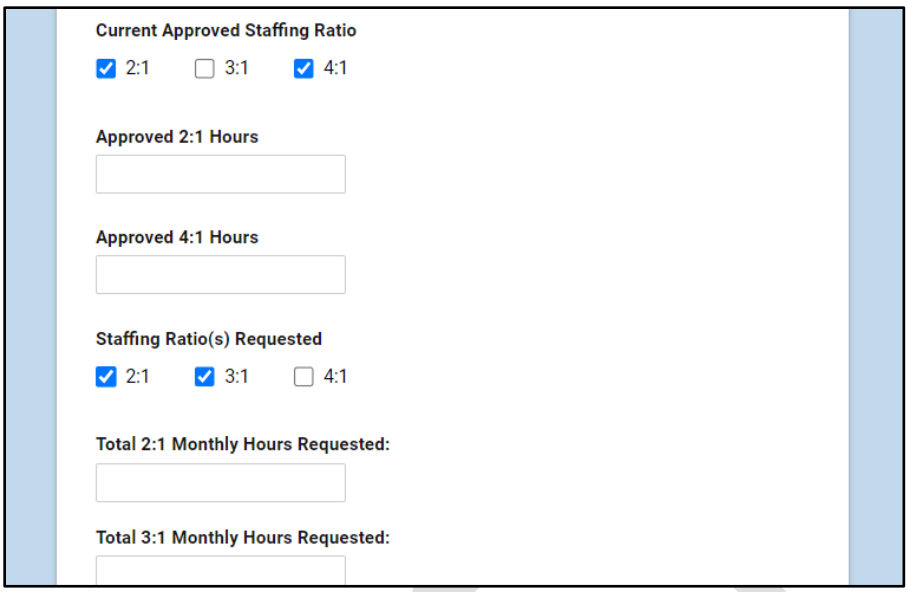
Risk of Isolation: Explain how the current hour allocation is used to meet other ADL, IADL, and health related tasks resulting in inadequate hours for community inclusion Describe the support needs that are not community inclusion that use all or close to all of the total hours available within the service group. Employment services do not count towards hours of community inclusion, but these do: IADLs that take place away from the home (laundry at a laundromat, banking, haircuts, etc.), Entertainment outside the home, Dining out, Attending religious services, Errands, Day Support Activities.

STAFFING RATIO EXCEPTIONS



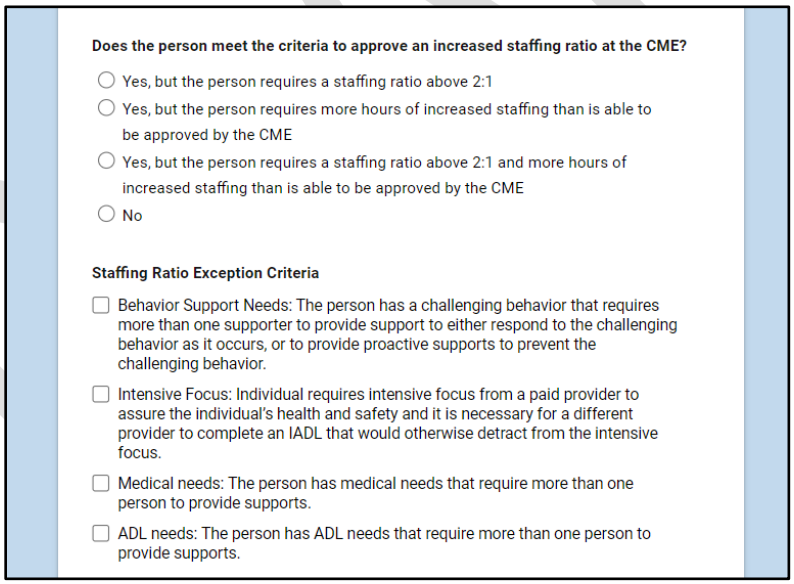
Request Type: Identify whether it is a new request, renewal request, increase from a previously approved exception or if the support need is time-limited.

***Note**: Exception start and end date will only open if the exception type is limited duration. If approved, exceptions will begin on the date of the memo and will end in 3 years for children and 5 years for adults or if a certified assessor completes an assessment and the SG goes up or down.



Current Approved Staffing Ratio: Identify the staffing ratio(s) that are currently approved and the number of hours for each approved staffing ratio.

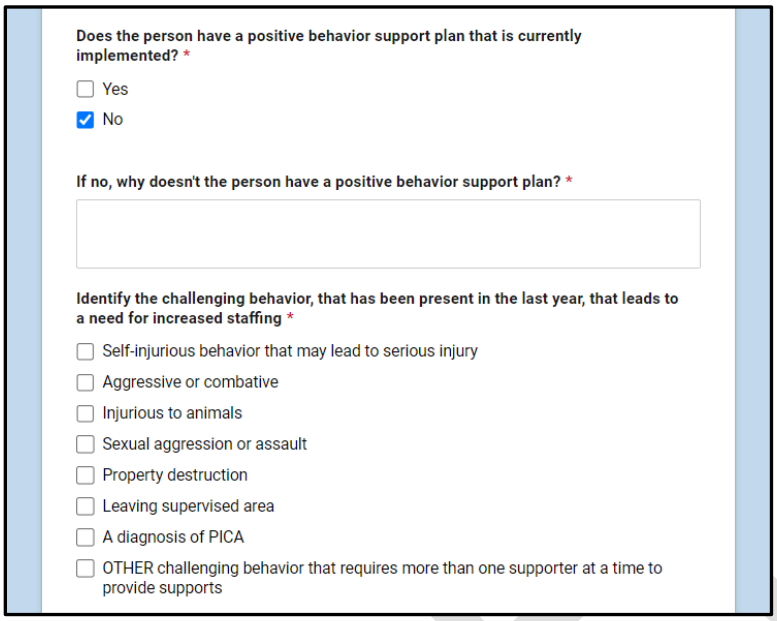
Staffing Ratio Requested: Identify the staffing ratio(s) that are being requested and the number of additional staffing ratio hours being requested for each ratio.



Does the person meet the criteria to approve an increased staffing ratio at the CME? Identify whether the individual meets the criteria for local CME approval.

Staffing Ratio Exception Criteria Identify all the criteria requiring a staffing ratio exception.

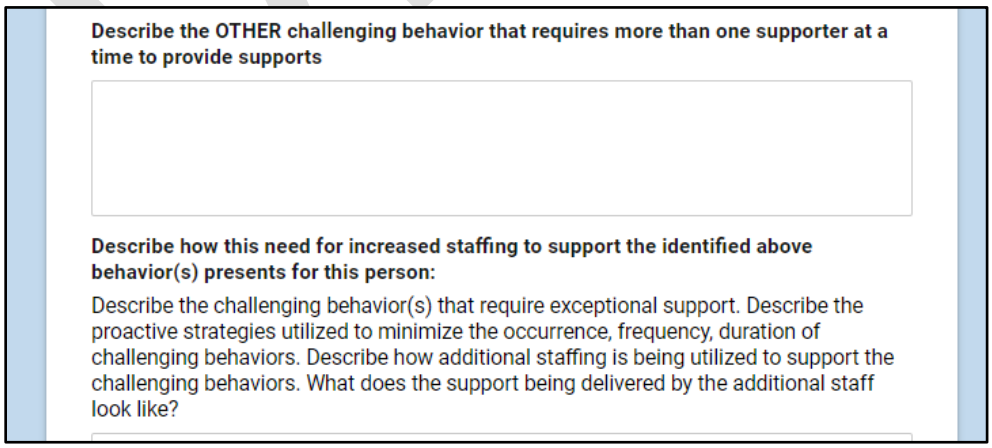
Staffing Ratio: Behavior Support Needs



Does the person have a positive behavior support plan that is currently implemented? Identify if the individual has a current Positive Behavior Support Plan.

- **If no, why doesn't the person have a positive behavior support plan?** Briefly describe why the individual does not have PBSP, or if the individual is in the process of having a PBSP developed.

Identify the challenging behavior(s), that has been present in the last year, that leads to a need for increased staffing Identify all challenging behavior present in the last year.



Describe the OTHER challenging behavior that requires more than one supporter at a time to provide support. Briefly describe the other challenging behavior that requires a staffing ratio exception.

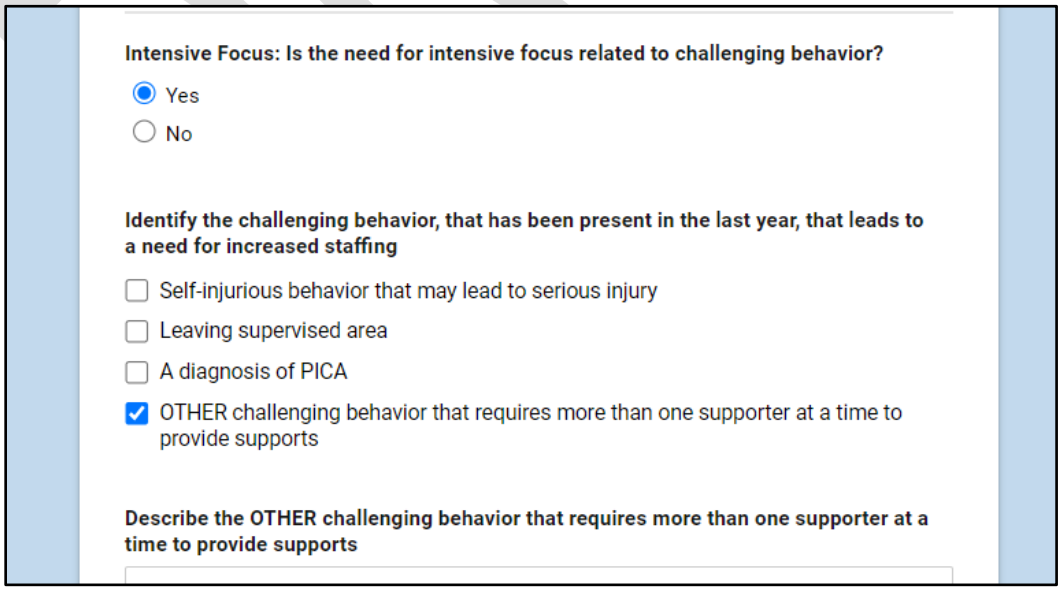
Describe how the need for increased staffing to support the identified above behavior(s) presents for this person: Describe the challenging behavior(s) that require exceptional support. Describe the proactive strategies utilized to minimize the occurrence, frequency, and duration of challenging behaviors. Describe how additional staffing is being utilized to support the challenging behaviors.

How often in occurrences per week does the need for additional staffing arise? Identify the average number of occurrences per week that the *behavior* support need arises.

Describe how long, in hours per day, the amount of time it takes to support this need Identify how many hours a day are needed to support the person's *behavior* support needs. If the daily support hours fluctuate during the week, use the daily average. This is done by calculating the total number of hours per week, divided by seven.

Behavior Staffing Ratio Being Requested Identify the staffing ratio(s) that are being requested and the number of weekly staffing ratio hours being requested for each ratio.

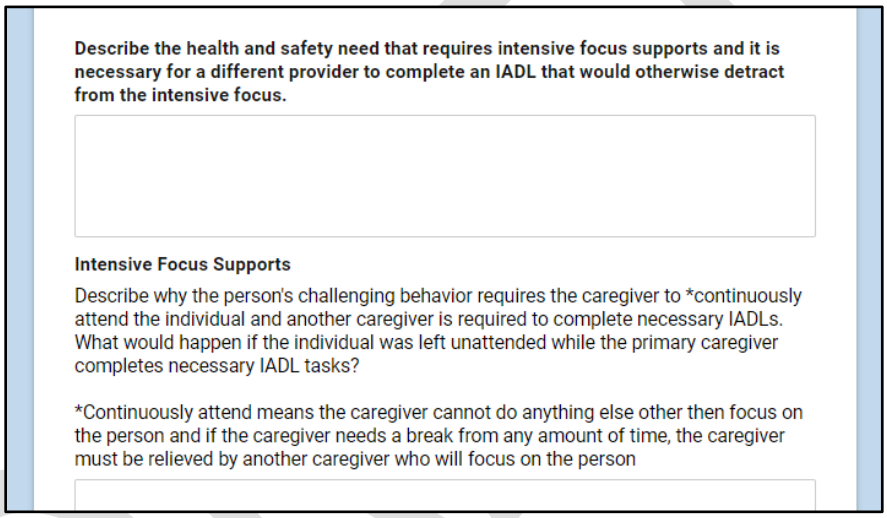
Staffing Ratio: Intensive Focus



Intensive Focus: Is the need for intensive focus related to challenging behavior? Identify if the need for exclusive focus is related to challenging behavior.

Identify the challenging behavior, that has been present in the last year, that leads to a need for increased staffing *(opens if the need for intensive focus is related to challenging behavior is marked yes*) Identify all the challenging behavior present in the past year.

- **Describe the OTHER challenging behavior that requires more than one supporter at a time to provide supports** Briefly describe the other challenging behavior that requires a staffing ratio exception.



Describe the health and safety need that requires intensive focus support, and it is necessary for a different provider to complete an IADL that would otherwise detract from the intensive focus. *(Opens if the need for intensive focus support is not related to challenging behavior)* Identify the health and safety support needs that require additional staffing.

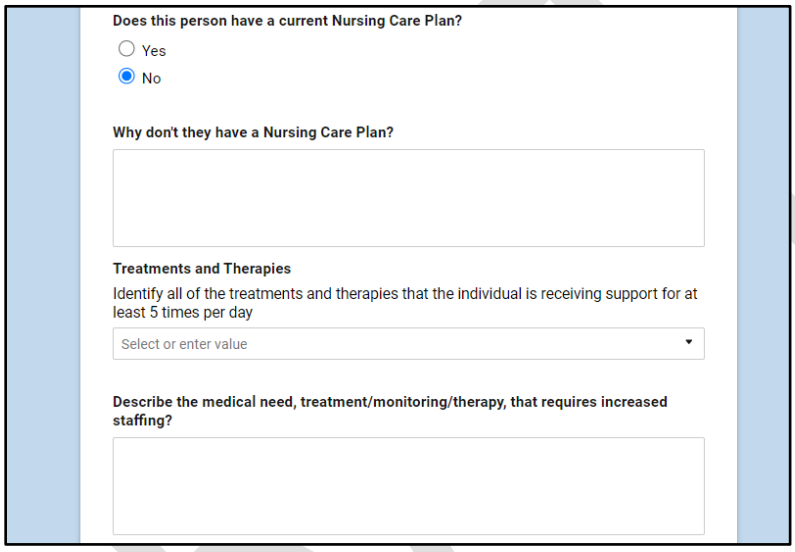
Intensive Focus Supports Describe the person's support that requires the caregiver to *continuously attend to the individual and another caregiver is required to complete necessary IADLs. Describe What would happen if the individual was left unattended while the primary caregiver completes necessary IADL tasks?

Intensive Focus: How often in occurrences per week does the need for additional staffing arise? Identify the average number of occurrences per week that the *intensive focus* support need arises.

Intensive Focus: How many staffing ratio hours are needed per day for intensive focus supports? Identify how many hours a day are needed to support the person's *intensive focus* support needs. If the daily support hours fluctuate during the week, use the daily average. This is done by calculating the total number of hours per week, divided by seven.

Intensive Focus Staffing Ratio Requested Identify the staffing ratio(s) that are being requested and the number of weekly staffing ratio hours being requested for each ratio.

Staffing Ratio: Medical Support Needs



Does this person have a current Nursing Care Plan? Identify if the person has a nursing care plan.

Why don't they have a Nursing Care Plan? Briefly describe why the individual does not have a nursing care plan.

Treatments and Therapies Identify all of the treatments and therapies that the individual is receiving support for at least 5 times per day.

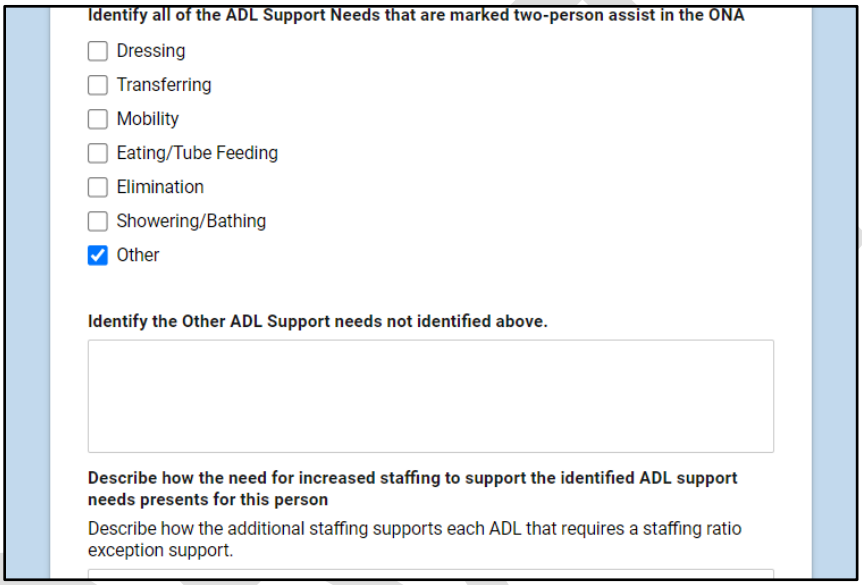
Describe the medical need, treatment/monitoring/therapy, that requires increased staffing? Describe the medical supports that require additional staffing. Describe how additional staffing is being utilized to support the medical support needs.

Medical Support Need: How often in occurrences per week does the need for additional staffing arise? Identify the average number of occurrences per week that the *medical* support need arises.

Medical Support Need: Describe how long, in hours per day, the amount of time it takes to support this need Identify how many hours a day are needed to support the person's *medical* support needs. If the daily support hours fluctuate during the week, use the daily average. This is done by calculating the total number of hours per week, divided by seven.

Medical Support Need: Staffing Ratio Being Requested Identify the staffing ratio(s) that are being requested and the number of weekly staffing ratio hours being requested for each ratio.

Staffing Ratio: ADL Support Need



Identify all of the ADL Support Needs that are marked two-person assist in the ONA Identify all of the ADL related supports. Failure to identify all ADL related support needs may result in incorrect form logic.

- **Describe the OTHER challenging ADL support that requires more than one supporter at a time to provide supports** Briefly describe the other support need that requires a staffing ratio exception.

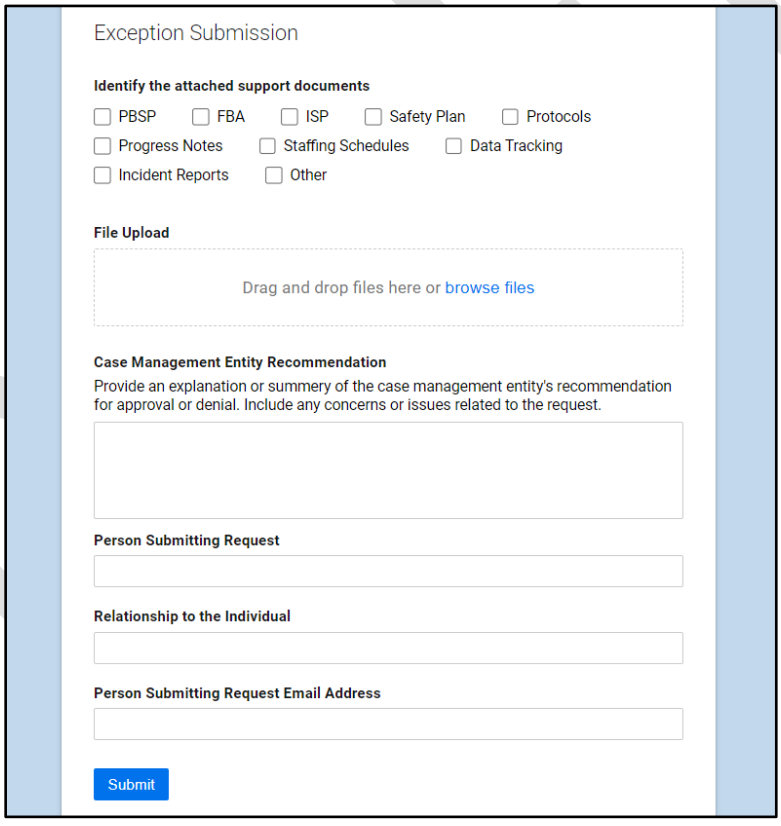
Describe how the need for increased staffing to support the identified ADL support needs presents for this person Provide a summary of the individual's ADL related support needs and why a staffing ratio exception is needed Describe the supports that are needed to support this need.

ADL Support Need: How often in occurrences per week does the need for additional staffing arise? Identify the average number of occurrences per week that the *ADL* support need arises.

ADL Support Need: Describe how long, in hours per day, the amount of time it takes to support this need Identify how many hours a day are needed to support the person's ADL support needs. If the daily support hours fluctuate during the week, use the daily average. This is done by calculating the total number of hours per week, divided by seven.

ADL Support Need: Staffing Ratio Being Requested Identify the staffing ratio(s) that are being requested and the number of weekly staffing ratio hours being requested for each ratio.

EXCEPTION SUBMISSION



Identify the attached support documents Identify what documents are being attached to this request.

- **What other documents are being attached?** Identify what documentation not identified above is being attached to this request.

File Upload Attach the supporting documents related to this request. If your files exceed the upload size or you have any other technical difficulties, please contact ODDS.FundingReview@odhsoha.oregon.gov for assistance.

Case Management Entity Recommendation Provide an explanation or summary of the case management entity's recommendation for approval or denial. Include any concerns or issues related to the request. Include any other information that is relevant to this request.