Exception Secondary Staffing Schedule

OREGON DEPARTMENT OF **Human Services**
Aging and People with Disabilities

Consumer name: _____ Prime ID: _____

Provider Name: _____ Provider Number: _____

Provide the staffing schedule to support this exception request, including how other exceptions and resident tiers are staffed. List the primary caregiver's schedule and relief staff exception shifts with names and exact start and end times. Do not use terms like "live-in", "available" or "on-call." Multiple resident initials can be assigned to one staff member when the care needs are unpredictable. Enter exceptional caregiving tasks on the Community-Based Care (CBC) Exception Calculator (Form 514). The staffing plan and payroll records must clearly show all additional staffing required by approved exceptions and tier assessments.

Primary Caregiver Staffing Example (Ex.):

Ex.	**Mon**		**Tue**		**Wed**		**Thu**		**Fri**		**Sat**		**Sun**	
Joe Doe	**In**	**Out**	**In**	**Out**	**In**	**Out**	**In**	**Out**	**In**	**Out**	**In**	**Out**	**In**	**Out**
	8AM	**7:59AM**	**8AM**	**7:59AM**	**8AM**	**7:59AM**	**8AM**	**7:59AM**	**8AM**	**7:59AM**	**OFF**	**OFF**	**OFF**	**OFF**

Primary Caregiver Staffing:

Primary Care Staff	Mon		Tue		Wed		Thu		Fri		Sat		Sun	
	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Name:														

Daytime Exceptional Relief Care Staffing (as needed):

Resident Initials	Relief Care Staff	Mon		Tue		Wed		Thu		Fri		Sat		Sun	
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														

Resident Initials	Relief Care Staff	Mon		Tue		Wed		Thu		Fri		Sat		Sun	
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														

Nighttime Exceptional Relief Care Staffing (if applicable):

Resident Initials	Relief Care Staff	Mon		Tue		Wed		Thu		Fri		Sat		Sun	
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														

Resident Initials	Relief Care Staff	Mon		Tue		Wed		Thu		Fri		Sat		Sun	
		In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Initials:	Name:														

Certification and Signature:

I certify that the staffing identified, and caregiving tasks as described on this form are true and accurate as of the date of completion. I understand and agree that:

- The request is not complete until all required items have been submitted, reviewed and approved by the Oregon Department of Human Services (ODHS) Aging and People with Disabilities (APD) Central Office (CO).
- Failure to provide accurate information or all required items may result in denial of the request.
- All exception hours approved by ODHS APD CO shall be staffed as funded by the exceptional payment(s).
- Staff funded by exceptional payment(s) shall be paid in accordance with all local, state and federal employment requirements. Select Bureau of Labor Industries (BOLI) for more information.
- Payroll documentation for staff funded by exceptional payment(s) shall be maintained and provided upon request by the Department.

Certification and Signature Continued:

- Exception hours for one resident are not simultaneously used for another resident.
- Failure to meet exception certification requirements may result in reduction or termination of exceptional funding.
- If approved, failure to provide residents the funded exceptional hours may result in an investigation by Oregon's Medicaid Fraud Unit.

Licensee/Administrator Printed Name:_____

Licensee/Administrator Signature:_____ Date:_____

Please contact the resident's case manager with any questions or concerns.
Locate your nearest Aging and People with Disabilities (APD)/Area Agency on Aging (AAA) office on the Find an Office site.

Need this document in another format?
You can get this letter in other languages, large print, braille, or a format you prefer for free.
Contact ODHS at apd.ltss@odhsoha.oregon.gov or at **503-945-5600 (voice/text)**. We accept all relay calls.

Clear Form