

In-Home Exceptions, Homecare Worker (HCW) Hourly Cap Exception or Shift Services Application

Updated: April 1, 2026

Name: _____

Date of birth: _____ Prime: _____

Your case manager may help you complete this application if necessary.

Type of Request

New Renewal

Application Type:

Request from consumer Request from case manager

Please provide the appropriate information below for each request made.

Shift Services (OAR 411-030-0068)

Shift Services is for individuals who need unscheduled hourly help with at least one in-home program task while awake. Your case manager can answer questions about specific eligibility criteria. You will need to provide a 72-hour care log demonstrating the hourly need and a statement explaining why shift services are needed.

Hourly Exceptions (OAR 411-030-0071)

Requesting additional in-home service hours requires you to list each task, how long it takes, how often it is needed per day and how many providers are required. Your case manager can explain this process. Use a separate sheet of paper for tasks or needs that don't occur on a regular schedule.

Please describe the reason(s) why the current hours are not meeting your current needs (if you are currently receiving hours). Describe specifically which needs are going unmet. Please include any other information that will help explain the need for the exception:

Oregon Aging and People with Disabilities (APD) may ask you for additional information including care provider time logs and medical documentation. You are required to provide information we need to approve the requested hours.

HCW Hourly Cap Exception (OAR 411-030-0072)

Reasons for HCW hourly cap exception request (please be specific):

Please describe why you cannot hire additional HCWs or in-home care agencies to meet your needs.

APD may ask for additional information including care provider time logs or medical documentation. You are required to provide information we need to approve the requested hours.

The information you provide on this form will be subject to verification and review by federal, state and local officials. By signing below, you certify all information is true and correct to the best of your knowledge. If found otherwise you may be subject to penalties.

Consumer or representative signature

Date

Consumer or representative printed name

You have the right to appeal our decision if we deny any part of this request.

For Local Office Use Only

Effective date: _____ Most recent CA/PS date: _____

Request type: _____ Provider type: _____

CM name: _____ CM email: _____

Manager name: _____ Consumer prime: _____

Manager email: _____

Have natural supports been discussed? Yes No

Have assistive devices or environmental
modification been discussed? Yes No

Were alternative living environments
discussed (e.g. AFH)? Yes No

Please identify who will be managing this service plan? _____

In-Home Provider Information

Details

Provider number(s): _____

Provider name(s): _____

Meets VDQ Requirements? Yes No Enhanced HCWs? Yes No

Hours

Allowed number of hours: _____

Requested exceptional hours: _____

Total requested hours: _____

For central office use only	Allowed	Exception	Total
Approved hours:			

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