Individual Consent to HCBS Limitation(s) Instructions

Purpose

This document provides instructions for completing the Individual Consent to HCBS Limitation(s) (APD 0556) form.

For definitions and a full explanation of the Home and Community-Based Services (HCBS) Individually-Based Limitation (IBL) process, refer to Oregon Administrative Rule chapter 411, division 4. Additional tools and information can be found on the Oregon Department of Human Services, HCBS website, under the APD program, at: https://www.oregon.gov/odhs/providers-partners/pages/hcbs.aspx

Terminology

AAA – Area Agencies on Aging

APD – Aging and People with Disabilities

HCBS – Home and Community-Based Services

IBL – Individually-based limitation

Individual – Resident for whom IBL is being proposed

Person centered service plan (PCSP) coordinator – For individuals who receive Medicaid, the PCSP coordinator is their Medicaid case manager

Private-pay – This means the individual pays for services themselves (i.e., Medicaid does not pay for services). There is no PCSP coordinator for Private-pay.

Third party witness/private-pay witness – Someone other than the provider who is proposing the IBL, and other than the individual for whom the IBL is being proposed. This cannot be a paid caregiver. This will be a

person designated by the individual or their guardian. It may even be another resident who has cognitive capacity, if that person is designated by the individual/guardian.

Individual-Specific information

Date printed: Date form is printed

Individual's birthdate: Individual's date of birth

Individual's name: Individual's preferred first name and last name

Provider's name: Name of provider

Private pay?: Select Yes or No from dropdown box

Yes = payment source is not Medicaid

No = payment source is Medicaid

Provider's address: Provider's physical address

Rights that may be limited

Enter the requested start and end dates for each of the proposed IBLs. If more than one is being requested, each one will need to be addressed in questions 1 through 6, below.

Requested start date: Date when proposed IBL would go into effect if approved

Requested end date: Date when proposed IBL would end if it goes into effect [*Note: IBL cannot be put in place for more than one year*]

Questions

Answer each question and sub-question on the form.

Question 1: Describe the IBL 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?
- Anything else to share?

Question 2: Describe the reason/need for the IBL, including assessment activities conducted to determine the need.

- What health or safety risk is being addressed?
- What outcome are you trying to achieve? What is/are the goal(s)?
- Assessment tool?
- Outreach?
- Consultation?
- Anything else to share?

Question 3: Describe what positive supports and strategies were tried prior to the decision to implement the IBL.

- Include documentation of positive interventions used prior to the limitation. What was the outcome? Why didn't they work, or why are they not being used?
- Include documentation of less intrusive methods tried, but which did not work.

Question 4: Describe how this IBL is the most appropriate option and benefits the individual.

- Why and how does implementing the limitation make sense for the individual's personal situation?
- Explain how the benefits outweigh the risks.

Question 5: Describe how the effectiveness of the IBL will be measured.

- Refer back to the goal(s) identified in Question 2 – how will effectiveness be determined?
- Include ongoing assessment and/or data collection.
- Include frequency of measurement.

Question 6: Describe the plan for monitoring the safety, effectiveness, and continued need for the IBL.

- Who is responsible to monitor?
- How frequently will it be monitored?
- How is the ongoing need for continued use of the limitation to be determined?
- What training will be provided to the resident and necessary staff?
- Have you attached the nursing assessment?
- Have you attached the doctor's order?
- Anything else to share?

Decision Summary

Start date: Date when IBL will go into effect, if it goes into effect
End date: Date when IBL will end, if it goes into effect
[*Note: IBL cannot be put in place for more than one year*]
Consent?: Select either Yes button or No button

Yes = Individual consents to proposed IBL

No = Individual does not consent to proposed IBL

Individual's initials: Individual (or their guardian/other designee) hand-written initials, confirming consent or non-consent to proposed IBL

Individual Statement

Print name: Individual's printed name
Signature: Signature of individual or their guardian/other designee
Date signed: Date of individual's signature

Feedback from the individual
This section is not required.

The individual may use this area to include any information they want to include (e.g., feelings about the proposed IBL). The information does not have to be about the IBL. It may also be used to document any conditions the individual may wish to apply to the IBL. For example, "Individual consents to IBL except on the following holidays…"

Statement by the person centered service plan coordinator or witness
This section should be completed when the individual signs the form, regardless of whether the individual consents or refuses to consent to the IBL.

Print name: Name of Medicaid case manager authorizing the IBL, or name of third party witness (not the provider or their staff; may be the individual's family, friend or other designee)
Phone number: Phone number of PCSP coordinator or third party witness
Signature: Signature of PCSP coordinator or third party witness

Date signed: Date the PCSP coordinator or third party witness signs the IBL [*Note: This date must be on or after the date the individual signs the IBL.*]

APD/AAA case manager (box): Medicaid case manager checks this box if they signed the form

Private-pay witness (box): Third party witness checks this box if they signed the form

<u>Footer</u>

Name: Individual's preferred first name and last name