Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Instructions for Individual Consent to HCBS Limitation(s)

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 (or their guardian/designated representative). This cannot be a paid caregiver. This will be a person designated by the individual (or their guardian/designated representative). It may even be another resident who has cognitive capacity, if that person is designated by the individual, their guardian or their designated representative. The

function of this witness is to ensure (for the protection of the provider and the individual) that there was no coercion to having the individual (or their guardian/designated representative) consent to the IBL.

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:	For residential services, use the physical address where individual lives; for non-residential services, use the provider's physical address

Rights that may be limited (see last page for a reminder about the use of bed rails)

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 individual 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/designated representative) must hand-write their initials next to each proposed IBL, confirming their consent, or non-consent, to each of the proposed IBLs

Individual statement

Obtaining the individual’s (or their guardian/designated representative’s) signature:

- For private-pay, the individual’s signature must be obtained at the same time the third party/private pay witness signature is obtained. The third party witness must ensure the individual (or their guardian/designated representative) understand the form and are freely signing it without coercion.
- For Medicaid, the provider must obtain the signature of the individual (or their guardian/designated representative) prior to submitting the IBL request to the Medicaid Case Manager.

Print name: Individual’s printed name (see note on page 6 re: Power of Attorney [POA])

Signature: Signature of individual or their guardian/designated representative

Date signed: Date of individual’s signature

Revoking consent:
If an individual (or their guardian/designated representative) revokes consent to the IBL, the provider may write “REVOKED ON [date of revocation]” on the form and have the individual (or their guardian/designated representative) sign and date underneath it. Providers will update the individual’s care plan. For Medicaid, the Case Manager will also update the individual’s Service Plan Agreement.

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/private pay witness (not the provider or their staff; and not the individual, their guardian or the designated representative who signed the IBL). This 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

Footer

Name: Individual's preferred first name and last name

Power of Attorney (POA)

The role of a POA does not necessarily cover IBLs. Regardless, if the individual has designated a person (which may be their POA), the POA may initial and sign on the individual's behalf. To be clear, the signature is not necessarily due to the POA role (unless the POA is for Medical purposes); it is specific to the individual having designated them as a representative who can sign on their behalf.

Reminder regarding use of partial bed rail in APD-licensed settings:

An assistive device can become restraining as the resident's condition changes, which should be part of their monitoring plan. Refer to the following Oregon Administrative Rules for full requirements on use of bed rails:

Adult Foster Homes: OAR 411-049-0102(86); 411-051-0130(14)

Adult Protective Services: OAR 411-020-0002(1), (39)

Assisted Living/Residential Care Facilities: OAR 411-054-0005(81), (92); 411-054-0060

HCBS: OAR 411-004-0010(19), 411-004-0020(1); 411-004-0040(3)

Intensive Intervention Communities: OAR 411-055-0310(31), (34), (36); 411-055-0365(7)-(15)

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact APD Medicaid Services and Supports Team at apd.medicaidpolicy@odhsoha.oregon.gov. or 503-945-6412 (voice/text). We accept all relay calls.