Developmental Disabilities Administration (DDA)

Request and Consent for Exception to Policy (ETP) for Use of Restrictive Procedures

Client's Name	Date of Birth	Community Protection Participant ☐ Yes ☐ No
Address	City	State Zip Code

Describe:

1) The specific behaviors the restriction procedure ETP is intended to address:

2) The proposed restrictive procedure(s):

3) How and when the procedure(s) will be used:

4) The criteria for termination of the procedure(s):

5) The plan for recording the use and effectiveness of the procedure(s), and

6) How the continued need for the procedure(s) will be assessed:

Explain the risks of using the proposed restrictive procedure(s):

Explain the risks of not using the proposed restrictive procedure(s):

Describe what less restrictive procedures were previously implemented and shown not to be effective:

Describe what less restrictive procedures will remain in place:

Does this client have a current legal representative? ☐ Yes ☐ No

If yes, provide the following:

Legal Representative's Name:

Legal Representative's Telephone Number:

Documentation

Attach the following documentation per DDA Policy 5.15, Use of Restrictive Procedures Community, or DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth:

- ☐ a. Observable behavioral definition of target behavior(s) that require the use of a restrictive procedure
- ☐ b. Observable behavioral definition of the behavior(s) that will replace the target behavior(s) and make the restrictive procedure unnecessary
- ☐ c. Functional assessment or psychosexual evaluation
- ☐ d. Description of positive behavior support strategies or proposed Positive Behavior Support Plan (PBSP)
- ☐ e. Description of restrictive procedure(s) requested
- ☐ f. Documentation of less restrictive interventions used including the data analysis used to determine less restrictive interventions are not sufficient along with the reasons why they are not successful
- ☐ g. Data collection plan to evaluate the effectiveness of the restrictive procedure(s)
- ☐ h. Monitoring and evaluation plan for the use of the restrictive procedure(s)
- ☐ i. The criteria that will cause the restrictive procedure to be removed from the person's plan
- ☐ j. Protections and training in place that ensure the restrictive procedure will not harm the person
- ☐ k. Written consent of the person
- ☐ l. Written consent of the legal representative
- ☐ m. Other (specify):

Provider Request and Approval of ETP

Agency's Name		Telephone Number (include area code)
Administrator's Signature	Date	Administrator's Printed Name

Guardian Consent to Use Procedures

Client's Signature	Date	Client's Printed Legal Name
Legal Representative's Signature	Date	Legal Representative's Printed Name

The consent is valid for months (not to exceed 12 months).

Case Resource Manager Review

Recommend Approval ☐ Yes ☐ No	Case Manager's Name	Date

Comments

Field Services Administrator or Psychologist Review

Final approval level required for this restrictive procedure (check one):

- ☐ RA Only
- ☐ RA and Division Director

Comments

Recommend Approval ☐ Yes ☐ No	FSA / Psychologist's Signature	Date	FSA / Psychologist's Printed Name

Regional Administrator's Decision		
☐ Recommend approval to Division Director and submit (if Director level approval is required). ☐ ETP approved for __ months (not to exceed 12 months). ☐ ETP denied. ☐ Resubmit with modification(s) as specified (or attach additional sheet):		
Comments		
Regional Administrator's Signature	Date	Regional Administrator's Printed Name
Division Director's Decision		
☐ ETP approved for _____ months (not to exceed 12 months). ☐ ETP denied. ☐ Resubmit with modification(s) as specified (or attach additional sheet):		
Comments		
Division Director's Signature	Date	Division Director's Printed Name