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| Text  Description automatically generated |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Request for Exception to Policy (ETP)** **for Use of Restrictive Procedures** |
| PRINT CLIENT NAME LAST | FIRST | MIDDLE | DATE OF BIRTH | COMMUNITY PROTECTION PARTICIPANT**[ ]**  Yes **[ ]**  No |
| ADDRESS | CITY | STATE | ZIP CODE |
| Procedure(s) for which exception is requested: |

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| Does this person have a legal representative? **[ ]**  Yes **[ ]**  NoIs the document current? **[ ]**  Yes **[ ]**  NoIf yes, provide the following: |
| LEGAL REPRESENTATIVE’S NAME | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| **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):  |
| **Agency Request ETP** |
| AGENCY’S NAME | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| ADDRESS | CITY | STATE | ZIP CODE |
| PRINT ADMINISTRATOR’S NAME | ADMINISTRATOR’S SIGNATURE  | DATE |
| **Case Resource Manager Review** |
| RECOMMEND APPROVAL**[ ]**  Yes **[ ]**  No | PRINT CASE MANAGER NAME | DATE |
| **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 |
| **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 |
| **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 |
| DIRECTOR’S SIGNATURE | DATE |