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| DDA Logo | 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  No  If 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, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth:  a. Definition of target behavior(s)  b. Functional assessment or psychosexual evaluation  c. Description of positive behavior support strategies or proposed Positive Behavior Support Plan (PBSP)  d. Description of restrictive procedure(s) requested  e. Data collection plan  f. Monitoring and evaluation plan  g. Written consent of the person  h. Written consent of the legal representative  i. 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 | | |