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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  No  Is the document current?  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 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 | | |