Comagine Health

Oregon Behavioral Health Support Program CH-003

Individually Based Limitations (IBLs)

Please note that individually based limitations can only be implemented for health and safety reasons and only with the consent of the consumer or their legal representative/guardian

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Comagine Health
www.comagine.org/obhsp

Oregon Behavioral Health Support Program

Form CH-003: IBL

An individually-based limitation (IBL) means any limitation to the qualities outlined in OAR 411-004-0020(1)(d) and (2)(d) to (2)(j), due to health and safety risks. An individually based limitation is based on specific assessed need and only implemented with the informed consent of the individual or, as applicable, the legal representative of the individual, as described in OAR 411-004-0040. The complete rule can be found here.

IBLs are only for individuals in home and community-based settings.

When requesting an IBL, providers should complete this form (CH-003-IBL), provide all the documentation outlined to support the implementation of an IBL, and submit to Comagine Health. Please complete a separate CH-003 form for each IBL requested.

Ensure the individual or, if applicable, their legal representative initials the limitation to ensure the individual's consent is accurately reflected. If the individual or, if applicable, the legal representative, does not agree or consent to the limitation, it may not be applied. The individual or, if applicable, the legal representative, is not required to consent to any proposed limitation.

- The individual or, if applicable, the legal representative needs to sign the form when complete.
- The provider must sign and date the provider statement, ensuring compliance.
- The form must be sent to Comagine Health.

Comagine Health will review the IBL, build it into the patient-centered service plan, and sign the CH-003-IBL form. A copy will be provided to the Individual and program. Please begin on the next page.

Note: Please submit PA requests via MMIS.

Link to OAR:
OAR 410-173-0040

- A separate CH-003 form is required for each limitation to be reviewed.
- Only one box should be checked on this page.

I. HCBS Individually-Based Limitation (IBL)

☐ New Limitation ☐ Update to Existing Limitation

Demographic Information

Date:	Date of Original IBL (if updating):
Provider Name:	
Provider Address:	
Individual's Name:	
Private Pay?	Yes ☐ No ☐
Medicaid ID:	

HCBS Individual Right to Be Limited

Select the limitation from the list below. This form must be submitted for each limitation applied.

- ☐ Freedom and support to access food at any time
- ☐ Have visitors of their choosing at any time
- ☐ Have a unit entrance door that is lockable by them with appropriate staff having access
- ☐ Choose a roommate when sharing a unit
- ☐ Furnish and decorate their bedroom unit as agreed to in the Residency Agreement
- ☐ The freedom and support to control their schedule and activities
- ☐ Privacy in their bedroom unit

Please review the OAR as needed to ensure attestation in all areas

All questions must be completed and supporting documentation attached

Provider Attestation for Limitation

I attest that the following have been carefully considered with the individual and does apply to the individual noted above (please review and check each box):

- ☐ The program quality threatens the health or safety of the individual or others.
- ☐ The individually-based limitation is supported by a specific assessed need.
- ☐ Have a unit entrance door that is lockable by them with appropriate staff having access.
- ☐ The individual or legal representative consents.
- ☐ The limitation is directly proportionate to the specific assessed need.
- ☐ The individually-based limitation will not cause harm to the individual.

Questions

Answers and evidential documentation to each question below is required. Skipped questions or answers that do not apply will be sent back to the provider for resubmission and the IBL may need to be suspended until resubmission. Please be clear, concise, complete and relevant in your answers.

1. Describe the Individually-Based Limitation to the Rule. (Who proposed this limitation? What is it? When will it be implemented? How often? By whom? How is the limitation proportional to the risk? etc.):

☐ Please check this box that all supporting documentation, which supports the answer to this question, has been attached to this form.

2. Describe the reason/need for the Individually-Based Limitation, including assessment activities conducted to determine the need. (What health or safety risk is being addressed? Assessment tool, outreach, consultation, etc.):

☐ Please check this box that all supporting documentation, which supports the answer to this question, has been attached to this form.

Please reference OAR for additional information to complete all questions [OAR 410-173-0040]

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried, but which did not work, etc.):

☐ Please check this box that all supporting documentation, which supports the answer to this question, has been attached to this form.

4. Describe how this Individually-Based Limitation is the most appropriate option and benefits the Individual. (Why/how does implementing the limitation make sense for the individual's personal situation?):

☐ Please check this box that all supporting documentation, which supports the answer to this question, has been attached to this form.

5. Describe how the effectiveness of the Individually-Based Limitation will be measured. (Including ongoing assessment and/or data collection and frequency of measurement.):

☐ Please check this box that all supporting documentation, which supports the answer to this question, has been attached to this form.

Please include PCSP planning team decision on frequency of IBL review

6. Describe the plan for monitoring the safety, effectiveness, and continued need for the limitation. (Who is responsible to monitor? How frequently? How is the ongoing need for continued use of the limitation to be determined? Etc.):

☐ Please check this box that all supporting documentation, which supports the answer to this question, has been attached to this form.

II. CONSENT, STATEMENT AND SIGNATURE

Based on the limitation marked in section I, complete the requested limitation by including start and end dates, indicate the appropriate consent, and please request that the individual, or if applicable, legal representative, initial the limitation to ensure the individual's consent is accurately reflected.

If the individual, or if applicable, legal representative, does not agree or consent to the limitation, it may not be applied. The individual, or if applicable, legal representative, is not required to consent to any proposed limitation.

Individually-Based Limitation	Start Date	End Date (cannot exceed one year)	Consent?	Individuals or Representative's Initials
Access to food at any time			Yes ☐ No ☐	
Visitors at any time			Yes ☐ No ☐	
Lockable doors			Yes ☐ No ☐	
Choice of roommate			Yes ☐ No ☐	
Furnish/decorate personal unit			Yes ☐ No ☐	
Control schedule and activities			Yes ☐ No ☐	
Privacy in room			Yes ☐ No ☐	

A separate CH-003 form is required for each limitation to be reviewed.

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Initials of Individual and/or Legal Guardian are required in both boxes

Signature of Individual and/or Legal Guardian is required

STATEMENT BY INDIVIDUAL OR LEGAL REPRESENTATIVE

I understand that I am NOT required to consent to any proposed limitation.

I have read the above information, or it has been provided to me in a format I can understand. I have had the opportunity to ask questions about this request and any questions that I have asked have been answered to my satisfaction. Where Individually-Based Limitations were discussed, I was given additional options. It was made clear to me that I do not have to agree or consent to any limitation. I agree to the sharing of this information with my care team, when appropriate.

Individual, or if applicable, legal representative, please review that your wishes to consent or not to consent are accurately captured in the box you have initialed above. Then print your name, sign, and date below.

Please review and initial the following:

☐ I understand that I can revoke our agreement with this IBL at any time.

☐ I have been given information regarding individual rights and contact information for advocacy from:

Residential Facilities Ombudsman Program
Phone: 1-844-674-4567
Email: rfo.info@oregon.gov

Disability Rights Oregon
Phone: 503-243-2081 or 1-800-452-1694

Name: _____

Signature: _____ Date: _____

Check the appropriate box for your role:

☐ Individual

☐ Legal Representative: Please attach a copy of the court order for decision making.

Please check the appropriate box of who consents to the IBL

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Provider information and signature required

III. PROVIDER STATEMENT AND SIGNATURE

Statement by Provider

I have reviewed the information for the above-named individual and to the best of my ability made sure that the individual understands the Individually-based Limitation process and has voluntarily consented to the Individually-based Limitation as documented on this form.

- I confirm that the individual was given an opportunity to ask questions about the Individually-Based Limitation.
- I confirm that the individual participated in problem solving different options.
- I confirm that all the questions in Section I have been answered to the best of my knowledge.
- I confirm that all evidential documentation will be submitted with this form.
- I confirm that the interventions and supports will not cause harm to the individual.
- I confirm that the individual has not been coerced into giving consent.
- I confirm that when consent has been given, it is done freely and voluntarily.

Provider, please print your name, sign and date below:

Name: _____ Title: _____

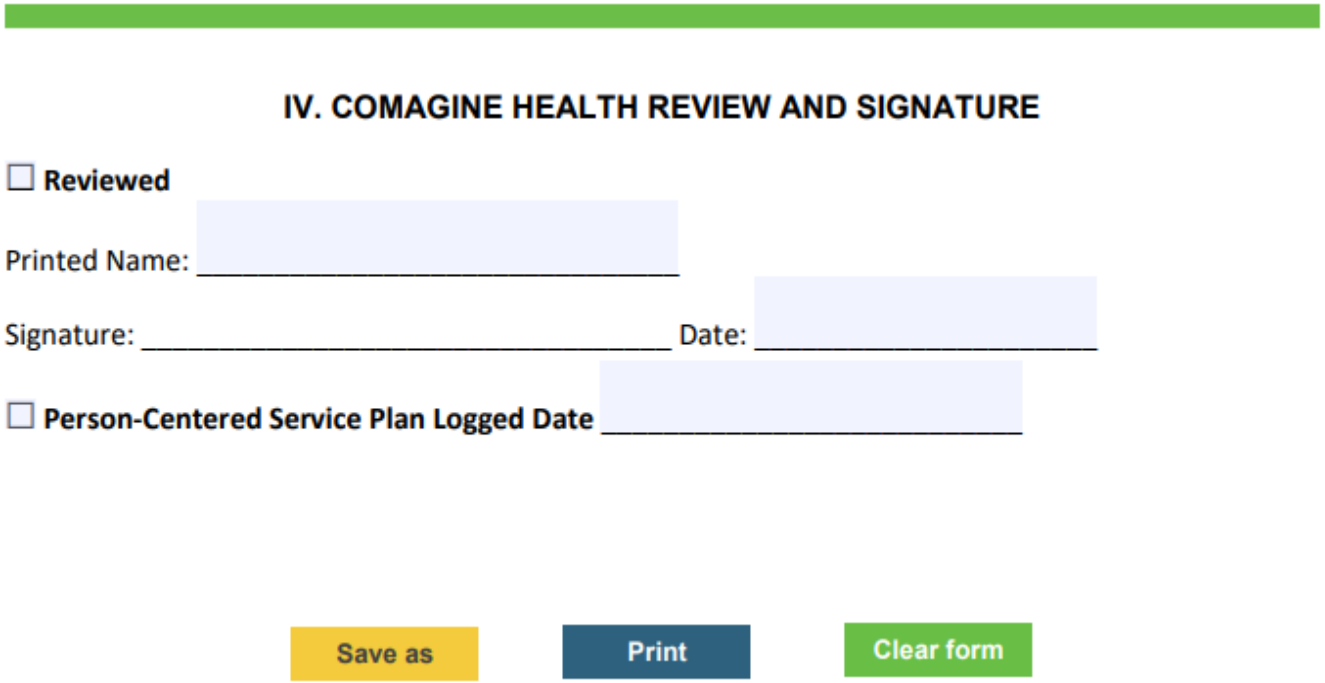
Signature: _____ Date: _____

Check the appropriate box for your role:

☐ Administration ☐ Counselor ☐ Other: _____

Date Sent to Comagine Health: _____

This page is to be completed by the Comagine Health Case Manager after review of IBL request and any supporting documentation



IV. COMAGINE HEALTH REVIEW AND SIGNATURE

☐ Reviewed

Printed Name: _____

Signature: _____ Date: _____

☐ Person-Centered Service Plan Logged Date _____

Save as Print Clear form

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Once the form is complete, please submit by email, fax, or mail.

Email: ORBHSupport@comagine.org

Fax: 877-575-8309

Mail: 650 NE Holladay St. Suite 1700, Portland, OR 97232