

Name of person: _____

Agency: _____

Date: _____

Waiver of the Standard Interim Per Diem Rate Request for Enhanced Supervision (1:1 Support)

1. Purpose of the 1:1 coverage:

Why is the person being supported with 1:1 staff ratio? What risk does this person present to themselves or others that require support of 1:1 staff ratio? What other less restrictive measures have been attempted to support the person?

2. Desired Outcomes of 1:1 Support:

What is the desired outcome of 1:1 supervision to preserve the safety and/or health of the person or others that can be expected to be achieved with this enhanced supervision? What **expanded interactions, activities, programs/training opportunities** will be provided by this enhanced coverage? If request is for renewal or continued **enhanced** 1:1 supervision, what is the effectiveness that the enhanced supervision has had over the last period? What **was the** baseline of incidents of behaviors when enhanced supervision began to now?

3. Fading Plan/Exit criteria:

What has the Team identified as the criteria that would need to be met to determine that enhanced supervision can be reduced or eliminated?

4. Data to be collected:

What criteria is documented to determine effectiveness of enhanced supervision and the progress toward the fading/exit criteria?

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Level of Supervision:

5. How staff will provide 1:1 support: (see examples below)

___ Line of sight: Staff assigned to 1:1 is present within twenty feet of the person. The person is always in the line of sight of the staff person. Staff interventions are to occur immediately.

___ Arms length: Within 12-24 inches (1-2 feet) of the person. Person constantly within sight of staff and staff intervention is to occur immediately.

___ Close Proximity: Staff within _____ feet of the person (not greater than 15 feet). Person constantly within sight of staff. Staff interventions are to occur immediately.

6. When 1:1 support will occur:

___ a. Continuous – Twenty-four (24) hours a day every day.

___ b. By shift(s). First Shift _____ Second Shift _____ Third Shift _____

___ c. Specifically, between the hours of _____ and _____.

7. Where 1:1 support will occur:

___ a. At all times - in every location.

___ b. Only in the following locations - Specify.

___ c. Specify exceptions. Example: bathroom, private bedroom, home visit, etc.

8. Enrichment Activities (In addition to expanded supervision and care, 1:1 coverage is also to provide expanded interaction, activities, programs and training opportunities beyond those that could reasonably occur without 1:1 unless medically contraindicated.) Please outline the enrichment activities. What activities or training programs that can increase the person's skills and independence can be worked on with the staff person providing the enhanced supervision? What are some of the person's preferred activities/interests that can be provided with the staff person providing the enhanced supervision?

Completed by: _____