

Residential Habilitation (ResHab) Documentation for Exceptions Requests

This form is used to document the hours of 1:1 ResHab service provided when a participant living in licensed or certified homes receiving ResHab services and requests an exception to their Individual Supports Budget. This may occur if the participant asks for more hours of base services, which are ADH, CLS-G or CLS-Ind. This form is not used to request Additional Residential Supports, which is a different service.

1. **Provider Agency Name:** _____

Participant Name: _____

2. **Check the box of “Allocated Staff Hours per Participant per Week” that is based on the Tier and Number of Beds.** For example, check the box next to the 6.7 hours for a participant with Tier 1 in a home of 3 or fewer beds.

Figure 1: Residential Habilitation Rate Model Staffing Assumptions

ResHab Tier	# of Beds	Allocated Staff Hours per Participant per Week <small>(the primary caregiver cannot provide these supports)</small>
1	3 or fewer	<input type="checkbox"/> 6.7 hours
	4	<input type="checkbox"/> 7.5 hours
	5 or more	<input type="checkbox"/> 8.0 hours
2	3 or fewer	<input type="checkbox"/> 20.0 hours <small>(same allocated hours regardless of # of beds)</small>
	4	
	5 or more	
3	3 or fewer	<input type="checkbox"/> 26.7 hours
	4	<input type="checkbox"/> 25.0 hours
	5 or more	<input type="checkbox"/> 24.0 hours

Resource: Medicaid I/DD Waiver Memo No.: FY2018-07, [Figure 1: Residential Habilitation Rate Model Staffing Assumptions](#)

3. **The provider selects the method used to determine the hours received:** *(select all that apply)*

- Daily Service Log
 Time Sheets (agency staff only)
 Observation of Service Delivery
 Other (specify): _____

4. **Based on the number of hours checked in Figure 1 above, I attest that:** *(select one)*

- The participant received all the minimum allocated 1:1 hours of ResHab service implementing ISP goals from a worker other than the primary caregiver/home manager.
 The participant received fewer hours per week than the allocated 1:1 hours and the remaining hours = _____
(fill in #)

5. **I acknowledge that supporting documentation is available to DDD upon request.**

6. **By signing, I attest I am authorized to sign on the provider agency’s behalf and the information in this document is true and accurate. Fax the completed form to the participant’s case manager within 14 calendar days of request.**

Print Name of Person Completing Form

Title

Signature

Date

For DDD Use Only
Received by: _____ (name of Case Manager)

Date Received: _____

- When a participant requests an exceptions review for base services above the Individual Supports Budget, the case manager will notify the ResHab provider to complete the ResHab Documentation for Exceptions Requests form (or provider's equivalent documentation).
- From the day the case manager notifies the ResHab provider, the provider has 14 calendar days to gather the information, complete the form, and submit it by fax to the case manager. The case manager will include this information in the request for exceptions review on behalf of the participant. This timeline is important because it will ensure a timely review of the participant's request.
- The provider completes the form or equivalent documentation that meets criteria per the instructions below. Incomplete forms or documentation will be returned for additional information.

INSTRUCTIONS FOR COMPLETING RESHAB DOCUMENTATION FOR EXCEPTIONS REQUESTS:

1. Fill in the provider agency name and the participant name at the top.
2. The table includes the hours of 1:1 ResHab service by someone other than the primary caregiver. Check the box under the right column titled "Allocated Staff Hours per Participant per Week" that is based on the Tier and Number of Beds. For example, check the box next to the 6.7 hours for a participant with Tier 1 in a home of 3 or fewer beds. The number of allocated hours corresponds to the hours included in the daily rate paid to providers for ResHab services. The source is the Final Rate Models 5/23/18 from Burns & Associates. It is posted on-line at <https://health.hawaii.gov/ddd/files/2018/10/HI-DDD-Rate-Models-05-23-18.pdf>
3. Select the method(s) used to collect the information about the hours of 1:1 ResHab services provided to the participant by another member of the household (Shared Living) or staff (Agency). The form includes some options for data collection but is not intended to require any specific approach. Check the box to indicate the method(s) used to determine whether the 1:1 hours of ResHab were provided and if using "Other", write in a brief description.
4. Complete data collection to determine how many hours of 1:1 services the participant receives in a typical week. Compare it to the hours checked in the table. If the amount of 1:1 hours is more than the hours in the table, check the first box in the section beneath the table. If the amount of 1:1 hours is less than the hours in the table, put the number of hours remaining in the corresponding line.
5. Check the box to indicate that documentation is available upon request.
6. Print the name and title of the provider staff completing the form. Sign and date the form before sending to the case manager.