

**Enhanced Staffing
Request and Evaluation Form**

This form is to be used by Support Coordinators to request new or continued Enhanced Staffing on behalf of a person in services. The Support Coordinator External will forward the form to the Crisis Assessment and Additional Needs Administrator for approval at dspd929-930@utah.gov. This form is to be submitted for persons receiving Residential Services that are requesting or are currently receiving 4 or more hours per day of 1:1 staffing at their residential site. Forms with missing information will not be reviewed.

Additional Funding Requested (please check):
Enhanced Staffing: New ___ / **Continue** ___

SECTION ONE:

Today's Date: _____

Name _____ **DOB:** ___/___/___ **Age** _____

Individual's ID# _____

Primary Diagnosis: _____

Provider(s) _____ **Site:** _____

Provider Contact _____ **Phone Number:** _____

Support Coordinator _____ **SCE Email:** _____ **Phone #** _____

Current Services Received: _____

Current Budget (State) \$ _____

Projected Budget (State) \$ _____ (Funds needed to maintain enhanced staffing).

Number of 1:1 staffing hours (# Residential hours at 1:1 staffing ratio) _____

1. Current Situation: Why is enhanced staffing necessary at this time? What additional supports are needed for this individual? (Attach additional documentation if necessary, e.g.: incident reports, medical reports, etc.) _____

2. What is the purpose or goal of the enhanced staffing? _____

3. How will the person benefit from receiving an enhanced staffing level? (Activities, programs, training opportunities, additional behavioral programming, etc., that would not be possible without the enhanced staffing.) _____

4. What less restrictive alternatives were considered? _____

5. Supervision – List the times and places where supervision is to be enhanced, as well as the level of supervision required.

A. In what locations will enhanced supervision be provided?

- In every location.
- Only in the following locations – specify _____
Specify exceptions e.g. Bathroom, private bedroom, vehicle, home visit. Indicate locations excluded, and instructions for those locations _____

B. During what times will-enhanced supervision be provided and at what level of supervision?

- Continuous – Twenty-four (24) hours a day every day.
- By shift(s). First Shift _____ Second Shift _____ Third Shift _____ Level of E.S. _____
- Specifically, between the hours of _____ and _____. Level of E.S. _____

C. Level of Supervision definitions (the following hierarchy is to be used for fading):

- Arms Length Supervision.** An assigned staff person must remain within 36 inches (3 feet) of the person, keep that person constantly within his or her line of sight, and be able to intervene immediately as needed.
- Close Proximity Supervision -** An assigned staff person must remain within _____ feet (no greater than 15 feet) of the person, keep that person constantly within his or her line of sight, and be able to intervene within five (5) seconds.
- Line-of-Sight Supervision -** An assigned staff person must remain within twenty-five (25) feet of the person, keep that person constantly within his or her line of sight, and be able to intervene as needed within ten (10) seconds.
- Heightened Supervision -** The staff in the area must know where the person is at all times, visually observe the person within _____ minute intervals (no greater than 15 minutes), and be able to intervene as needed.
- General Supervision -** The level of supervision is no greater than for anyone else in the same area, and is provided through established staffing patterns and routines.

D. Explain what specific activities will this staff be engaged in while supporting the individuals at a 1:1 staffing ratio?

6. What are the exit criteria or plan to reduce and/or eliminate Enhanced Staffing? (Estimated date/goal date?)

7. If the request is for behavioral issues, is the behavior support plan current and effective (attach a copy of the current plan and three months of behavior monthly summaries)? _____

ANSWER FOR CONTINUATION REQUESTS FOR ENHANCED STAFFING ONLY

8. Does the monthly summary documentation support the effectiveness of the enhanced staffing (attach copies of the past three months of monthly summaries)? _____

The Request is: DENIED APPROVED __ 3 months __ 6 months __ 9 months __ One year

Administrator’s signature: _____ Date: _____

FOLLOW-UP INFORMATION REQUESTED: _____

DATE FOLLOW-UP INFORMATION WAS RECEIVED BY THE CRISIS ASSESSMENT & ADDITIONAL NEEDS TEAM: _____

ADDITIONAL INFORMATION: _____
