Utah Department of
Health & Human Services
Services for People with Disabilities

ENHANCED STAFFING

Request and Evaluation Form

Form 930 Version Date: March 2025

Privacy Notice: The information you provide will be used to determine continued eligibility for division services. It will only be used by DHHS and, if needed, by individuals or parties contracted with DHHS. Without this data, we cannot make a determination. This data is part of record series: 15376.

This form should be completed by the support coordinator (SCE) on behalf of any Person who is requesting, or who is currently receiving, *four or more hours per day of 1:1 staffing* at their residential site. The form should be completed and signed by the support coordinator and then uploaded to the Document section of USTEPS. It should be updated annually, or whenever staffing ratios are changed to increase additional 1:1 staffing.

FORMS WITH MISSING INFORMATION WILL NOT BE REVIEWED.

TODAY'S DATE:

NAME OF PERSON: **DOB:**

PERSON'S ID:

PRIMARY DIAGNOSIS:

PROVIDER(S): **SITE:**

PROVIDER CONTACT: **PHONE NUMBER**:

SUPPORT COORDINATOR:

SCE EMAIL: **PHONE NUMBER**:

SERVICES CURRENTLY 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 documention if necessary, ie., 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. Which less restrictive alternatives were considered?

5. Supervision - as appropriate fo A-D, list the times and places where supervision is to be ehnhanced, including the level of supervision required.

A. In what locations will enhanced supervision be provided?

☐ In every location.

☐ Only in the following locations:

Specify exceptions (ie. bathroom, bedroom, vehicle, home visit, etc,).
Indicate excluded locations, and the instructions for those locations:

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

☐ Continuous - 24 hours a day, every day.

☐ By shift(s). First shirt 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 should be used for fading):

☐ ***Arms Length Supervision*** - An assigned staff 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 member 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 the staff will be engaged in while supporting the individual 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 due to behavioral issues, is the behavioral support plan current and effective? (attach a copy of the current plan and three months of monthly behvior summaries).

ANSWER QUESTION 8 ONLY FOR REQUESTS TO CONTINUE ENHANCED STAFFING:

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

APPROVAL - SUPPORT COORDINATOR

Signature: Date: