DHS
Oregon Department of Human Services
Aging and People with Disabilities
Behavior Support Services

Request for Behavior Support Services

Case manager name:			Date of request:
Case manager email:		Case manager phone number:	

Supervisor name:	Phone:	Email address:

Client name:	Prime number:	Date of birth:
Client address:		

Provider/family/friend information *(person at individual's home or who is involved in client's life/care that can set-up visits and provide information, if different than the requestor)*:

Name:		Relationship:	Phone:
Address:		Care setting type:	

The case manager has authorized this referral for the following reason(s):

- ☐ Evicted or Adult Protective Service (APS) clients who are in a new "post crisis" placement and the provider/caregiver will need help to assure that the new placement is successful.
- ☐ Clients in a Community Based Care (CBC) setting who have received a move out notice or are facing eviction.
- ☐ Diversion clients who might need Behavior Support Services (BSS) to avoid nursing home placement.
- ☐ Any behaviors that are of concern: to the licensee, the caregivers or the case manager.
- ☐ A client who is receiving mental health clinic services, such as medication management but the care provider needs help managing the client's behavior or mental health symptoms.
- ☐ A client who is receiving psychotropic medication for behavior but there is no behavior support plan in place.

(Continued on next page.)

- ☐ Memory care or special needs contractors who want consultation on a complex client.
- ☐ In-home agency and foster home clients with either a behavior add-on rate or an exception rate which is based on the client's complex behavioral needs.
- ☐ The client or provider/caregiver would benefit from person centered planning that focuses on activities and interests to increase quality of life.
- ☐ The Medicaid in-home client or family requests the BSS.

Brief summary of specific client issues:

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I have informed the following persons of this request *(check all that apply)*:

☐ ALF/RCF Administrator ☐ AFH licensee ☐ Client/representative

☐ Caregiver(s) ☐ The family *(if involved)* ☐ Doctor and/or contract RN

If accepted, TOTAL number of hours authorized *(40 hours maximum)*: ____________

Case manager/point person *(e-signature is acceptable)*: Date:

Behavior Support Services use only
BSS referral/response: ☐ Accepted ☐ Pending/wait list ☐ Denied
If denied, reason for denial: ____________________ BSS provider no.: ____________
Behavior consultant: ____