As your provider, we have identified something you want to do that might create a risk. We need your input to develop a plan that supports you to have what you want in a safe way. We have determined that this restriction is necessary to achieve a therapeutic benefit, maintain a safe and orderly environment, or to intervene in an emergency and that all possible less restrictive options have been tried. [12VAC35-115-100].

The following is completed with the individual:

I understand that I will not: [Enter description of restriction]

This is necessary because: [Enter description of the reason for the restriction]

The outcomes in my plan related to this restriction include: [Enter the outcomes from the person’s ISP related to the restriction]

The following is completed by a qualified professional:

Describe your assessment, to include all possible alternatives to the proposed restriction that take into account the individual’s medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently: [Enter assessment results]

Describe other less restrictive, positive approaches that have been attempted to meet safety needs based on the person’s medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently: [Describe other less restrictive, positive approaches attempted]

Is this proposed restriction necessary for effective treatment of the individual or to protect him or others from personal harm, injury, or death?

Yes

No

Describe how progress toward resolving the restriction(s) will be measured: [Describe how progress will be measured]

Describe how often restriction(s) will be reviewed: [Enter frequency of review]

Describe conditions for removal of restriction(s): [Describe conditions for removal of restriction]

I understand that taking the actions listed can create a safety risk. I understand the reason for the restriction, the criteria for removal, and my right to a fair review of whether the restriction is permissible. When utilized, I understand that the proposed restriction will not cause harm and give my consent to participate:

Individual ___________________________________________ Date __________

Substitute Decision Maker ___________________________________________ Date __________

Responsible provider ___________________________________________ Date __________

Restrictions on the Freedoms of Everyday Life

The Safety Restrictions form is completed only when a Restriction on Freedoms of Everyday Life as defined in the Human Rights Regulations (12VAC35-115-100) is being put in place with an individual.

It is completed with the individual/substitute-decision maker’s signed consent and details specific conditions regarding the restriction. These conditions are detailed in Virginia’s Human Rights Regulations and in the Centers for Medicare and Medicaid Home and Community Based Services Rule (published January 16, 2014).

The contents are developed with the individual by a qualified professional, which is someone employed by the provider who is supporting the person and has knowledge of the information needed to complete the form.

This form is not completed for the use of restraints, to include protective devices (i.e. helmets/gait belts). Restraints are defined in {12VAC-115-110} of the Human Rights Policy.