OKLAHOMA DEPARTMENT OF HUMAN SERVICES
Developmental Disabilities Services Division (DDSD)

Exception Request for Waiver Employment Services

Service recipient	DDSD case manager (CM)	
Residential provider	Meeting date	Date submitted
Employment provider	Plan of care (POC) start date	
DDSD case management supervisor	Residential type	

Exception type: Check exception request type and complete narrative in the applicable sections.

- **Fewer than 30 hours of employment services.** Complete a, b, c, and d. ☐
- **More than 15 hours center-based services.** Complete a, b, and c for Homeward Bound Waiver only. ☐
- **More than 15 hours continuous supplemental in center.** Complete a, b, and c for Homeward Bound Waiver only. ☐
- **Alternative community-based activities.** Complete a, b, and c. ☐
- **Additional non-federal medical units.** Complete a, e, and f. ☐
- **Other exception:** _____. Complete a, b, and c. ☐

a. Current specific situation that requires an exception:

b. All employment efforts, successful and unsuccessful, made by the service recipient and Team in the past year:

c. Plan with specific steps and target dates to address the situation throughout the POC year so the exception may be lessened, or no longer necessary, at the end of the POC year:

d. Specific plan to provide a meaningful day in the community for service recipient while the plan to increase to 30 hours is implemented: List specific community activities in which the service recipient will participate and hours per week in each activity.

e. Specific medical issues necessitating exception: Provide history of 150 non-federal medical units used with dates, units, and reason units were billed.

f. Non-federal medical units needed to complete state fiscal year, July 1 through June 30:

Recommendation:

Meets exception criteria ☐
Does not meet exception criteria ☐

Exception type:

Employment Services Unit staff signature _____ Date _____

Approved ☐ Denied ☐

DDSD CM supervisor signature _____ Date _____

Approved ☐ Denied ☐

DDSD area manager signature _____ Date _____