REQUEST FOR OPWDD CERTIFIED SITE BASED PROGRAMS
EMERGENCY OR TEMPORARY RELOCATIONS OR INCREASE IN CAPACITY

Please submit the following with (or as soon as possible after) the completed form:

1. Revised fire evacuation plan and training.
2. Documentation of a fire drill conducted within 24 hours of the relocation/capacity increase.
3. Training Roster/documentation indicating that staff unfamiliar with any individual/individuals/have completed training on what must be done to meet the needs of the individual(s). Also, if applicable, documentation indicating that staff, even if familiar with individuals, have received training to meet needs in a new/different/unfamiliar environment or when accommodating a larger number of individuals (if capacity increase).
4. A revised protective oversight plan for IRAs or staff plan for ICFs which reflects the residential team has evaluated the staffing needs and determined what, if any, changes are required.

Agency Name:		
Request Type (Check all that apply):	Yes	No
Is this a request for a temporary relocation?	☐	☐
Is this a request for increase in capacity?	☐	☐
Can the physical plant support the needs of the individuals?	☐	☐

Expected start date of relocation and/or capacity increase:	
If this emergency relocation and/or capacity increase has already occurred, indicate date of occurrence:	
Reason for relocation and/or capacity increase:	
Expected duration of relocation or capacity increase?	
Is the relocation destination an OPWDD certified facility?	

Originating Site Information:	**Receiving Site Information:**
OC#:	**OC# :** (Please indicate **Not** if not a certified site)
Address:	**Address:**
Certified capacity:	
Current Census:	**Certified capacity:**
Staffing ratio per shift:	**Planned capacity:**
Day: Evening: Night:	**Staffing ratio per shift** (please include hours for shift): **Day: Evening: Night:**
RN coverage:	**RN coverage:**
Life Safety Code designation (if applicable):	**Life Safety Code designation (if applicable):**

Required Questions	Yes	No	Notes:
Is this an ICF emergency relocation?	☐	☐	
If yes, was the Emergency Plan activated?	☐	☐	
Have you ensured all the staff are trained on all COVID-19 universal precautions?	☐	☐	
A fire evacuation plan has been developed to meet the needs of all individuals under the new living conditions?	☐	☐	
Have the staff received training in the fire evacuation plan and procedures?	☐	☐	
Does the current site meet or exceed the LSC designation of the originating site?	☐	☐	
If "No", what measures are being taken to compensate for individual's safety.			
Have the needs of the individuals been reviewed to be adequately addressed in all areas?	☐	☐	
Have the staffing needs been reviewed and staffing minimums and assignments adequately determined in relation to individuals' specific needs and other program needs?	☐		
Is anyone enrolled at this site temporarily staying elsewhere? (i.e. hospital, rehab, etc.)	☐	☐	If yes, please list date expected to return, if known:
What actions are needed in order for the temporary increase or relocation to end?			Please provide details and estimated timeline of completion:
Are any Willowbrook Class Members impacted?	☐	☐	If yes, please list names and TABS ID:
If yes, has Consumer Advisory Board been notified at 718-477-8800?	☐		CAB Staff name/Title/Date of Notification:
If a relocation, has the Care Manager been notified?			Please list name/Title/Date of Notification:
Has the relocation been explained (as able) to the individuals impacted?	☐	☐	Please list names and TABS ID of Individuals impacted:
Have notifications been made to individuals' families, advocates, etc.?	☐	☐	Family/advocate name/Title/Date of Notification:
DDRO notified (required)	☐		DDRO staff name/Title/Date of Notification:

Requests for a temporary increase in capacity or temporary relocation are approved for 30 days. Requests for an extension must be sent to the Bureau of Program Certification **prior** to the end of the 30-day period. Temporary relocations/ increases in capacity *can be approved for up to 90 days*. If a temporary relocation results in permanent relocation, it requires the agency to follow the appropriate discharge process including: RFO support, CON/CPPC approvals and due process.

AGENCY Contact: I attest that the above information has been reviewed by the appropriate team members and determined to meet the current needs of the individuals and regulatory requirements for the program(s). **Name:**_____ **Title:**_____ **Date:**_____
AGENCY CEO/DIRECTOR APPROVAL: **Name:**_____ **Title:**_____ **Date:**_____
OPWDD Division of Quality Improvement, Bureau of Program Certification has reviewed and accepted. **Name:**_____ **Title:**_____ **Date:**_____