[ ]  EMERGENCY [ ]  NON-EMERGENCY [ ]  ON-GOING

|  |  |  |  |
| --- | --- | --- | --- |
| Provider: |       | FEIN # |  |

|  |  |
| --- | --- |
| RDID# of program where supports are being requested: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Individual: |       | DDS #  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| LON Score | Composite |  | Behavioral |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Res Request  | [ ]  | Annual Res Funding |  |
| Day Request  | [ ]  | Annual Day Funding |  |

Supports being requested:

[ ]  Staff Support General For additional staffing agency is required to provide the first two weeks per occurrence. Include dates provider provided two weeks of support in details of request

[ ]  Staff Support Behavior Consultative Services, Residential agency is required to provide first 40 hours annually. Day supports may request up to 15 hours annually

[ ]  Staff Support Medical, Based on Clinical Plan requires Regional Director approval

[ ] Equipment, Capitol over$5,000 documentation indicating no other funding source is available attached

[ ] Equipment, Non-Capitol under $5,000 documentation indicating no other funding source is available

[ ] OT, PT, Speech only after Title XIX denial and appeal documentation is attached

|  |
| --- |
| [ ] Other Detail: |
| Dates Support being requested: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hourly amount: |  | Hours per week |  | # of weeks |  |

|  |  |
| --- | --- |
| Total Amount: |  |

|  |  |
| --- | --- |
| Service Currently being provided: |  |

|  |  |
| --- | --- |
| Current staffing pattern: |  |

Describe in detail specific supports being requested:

|  |
| --- |
|  |

What are the specific clinical needs of the individual necessitating the request?

|  |
| --- |
|  |

What other Modifications have been tried, and what where the results?

|  |
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|  |

What is the fading plan to reduce reliance on additional support?

|  |
| --- |
|  |

The above named Provider agrees that the temporary supports funded through this request will be provided to the named individual, that the supports rendered will be as described by this request, and any overpayments made by the Department of developmental Services under this agreement will be refunded to the department. Effective July 1, 1999, one-time amendments will be cost settled at 100% recovery.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Provider: |  |  Date:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Resource Manager Review:  |  | Date:  |  |

Regional Response

 [ ]  Emergency Authorization

 [ ]  The request meets the needs of the individual and the established parameters of the onetime procedure and is authorized. Funding is subject to availability of resources.

 Amount Approved

[ ]  The request meets the needs of the individual and the established parameters of the onetime procedure however, funding is not available at this time. When funding becomes available request will be reconsidered.

[ ]  The request is denied Reason

[ ]  Additional Information is needed Describe

Signature of Regional Designee       Date