

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
Staff Add-on Request for Client Specific Need

VENDOR NAME AND PROVIDER NUMBER		HOUSE NAME (FOR LICENSED STAFF RESIDENTIAL (LSR) ONLY)	
Client Specific Add-On			
DATE	CLIENT NAME	ADD-ON HOURS REQUESTED (Specify day/week/month)	
START DATE FOR REQUESTED SERVICE		ESTIMATED ENDING DATE FOR REQUESTED SERVICE (Maximum of three months from date of initial request)	
REASON/JUSTIFICATION FOR REQUEST:			
GOALS FOR USING REQUESTED HOURS:			
TYPE OF ADD-ON REQUEST (CHECK ONE) Request must be submitted and approved by DDA prior to vendor providing additional staffing. <input type="checkbox"/> Emergency Telephone Approval By: _____ Date: _____ <input type="checkbox"/> Initial Request Submit a staff schedule for the home reflecting where the requested hours will be utilized. <input type="checkbox"/> Continuation Date of initial request not to exceed 90 days, per policy, without an approved ETP. Please attach an updated plan. If this is a continuation request, has the Positive Behavioral Support Plan (PBSP) been updated (Please attach) or a medical justification letter been included? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
RESIDENTIAL PROVIDER SIGNATURE			DATE
Completed by DDA Social Worker (SW) / Resource Manager (RM)			
<input type="checkbox"/> Recommend <input type="checkbox"/> Do Not Recommend <input type="checkbox"/> Partially Recommend		FUNDING SOURCE <input type="checkbox"/> Waiver <input type="checkbox"/> State Only <input type="checkbox"/> SSP <input type="checkbox"/> Other:	
COMMENTS:			
MONTH	HOURS	RATE	TOTAL
CRM/SW SIGNATURE			DATE
RM/VPS SUPERVISOR SIGNATURE (FOR LSR PROGRAM ONLY)			DATE
FSA/DESIGNEE SIGNATURE			DATE
<input type="checkbox"/> Approve <input type="checkbox"/> Deny <input type="checkbox"/> Approve with Changes			
COMMENTS:			

COPY TO: Client File, VPS SW, VPS Coordinator, HQ VPS Program Manager, Vendor, DDA RM (Supported Living only)