**Date:**       **DBHDD Region:**      **Individual Name:**

**Provider:       Provider Contact Person/Phone:**

**Community Residential Alternative:  Host  PCH  CLA**

**Community Living Support:**

**Live with family/caretaker  Live on own  Shared Arrangement**

**Reason for Request*: (Required: Please attach documentation to A-D questions checked below)***

1. **Justification of additional hours or additional staff.**
2. What prompted request? i.e.: change in condition or continuation due to extraordinary needs. Describe request need and all current services frequency/unit services the participant is receiving?
3. Usage of hours within model: Please attach weekly staff schedules representing usage of hours for each resident within the home?
4. How you are planning to use the additional hours? Please provide detail information as to when and how the additional hours will be utilized.
5. Completion of Additional Residential Staffing Template?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CHECKLIST: PERTINENT RECORD DOCUMENTATION** | | | | |
|  | Current service plan *(Refer to CIS).* |  | \*Recent progress notes (case management, residential) | |
|  | BSP, Behavior data tracking etc *(Please upload in CIS Documents)* |  | \*Relevant legal documentation | |
|  | Safety/Crisis Plan *(Please upload in CIS Documents)* |  | \*Recent incident reports | |
|  | \*Medical support plan, Healthcare Plans/protocols |  | \*Additional information: school records, IEPs, personal statement from past caregivers, proof of home modifications, doctor's notes, hospitalizations etc. | |
| *\*Refer to Provider Records*  **-------------------------------------DBHDD Field/Central Office Usage Only-----------------------------------------**   |  |  | | --- | --- | | **Date Received from Provider:       Date Received from Field Office:** | | | **Regional Clinical Reviewer:**  On Site  Observation of Individual  Conduct Interview (staff/participant)  Review of On-site Records  Assessment uploaded in CIS | **Central Office Clinical Reviewer**  Discussion with First Reviewer  Documentation Review  Assessment Determination Review  Utilization Review: Usage of Hours vs Additional Hours | | **Central Office Review Outcome:**  Authorization: Additional hours and/or staff & specifications:  Additional Recommendations: | | | **If Applicable:**  Appeal Notification: | |   **Regional Clinical Reviewer:       Date:**  **Central Office Clinical Reviewer:       Date:** | | | |  | |  |  |  |  |