**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? [ ]

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| **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-----------------------------------------**

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| **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:** |  |  |  |  |  |