Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITITIES ADMINISTRATION (DDA)

DDA Request for Additional Units
Nurse Delegation (ND)

1. RND NAME	2. RND TELEPHONE NUMBER	3. RND E-MAIL ADDRESS
4. CLIENT'S NAME	5. ACES ID NUMBER	6. CLIENT'S DATE OF BIRTH
7. CASE MANAGER'S NAME	8. CASE MANAGER'S TELEPHONE NUMBER	9. CASE MANAGER'S E-MAIL
10. DDA NURSE DELEGATOR COORDINATOR'S NAME	11. COORDINATOR'S TELEPHONE NUMBER	12. COORDINATOR'S E-MAIL

13. I will need _____ more units in addition to the 100 units already authorized for the month of _____. This will allow me to bill for a total of _____ units for the month of _____.

14. Reason additional units needed (check all appropriate boxes below):

A. **For insulin,** complete the section below (no additional narrative required).

- ☐ Initial visit; _____ units needed.
- ☐ Supervisory visit; _____ units needed.
- ☐ New support providers / caregivers; _____ units needed.

Total number of caregivers delegated insulin: _____

B. **Other than insulin,** please list reason(s) units needed:

15. DATE REQUESTED	16. REQUESTING ND SIGNATURE	
17. UNITS APPROVED	18. ND / NURSE SERVICE PROGRAM MANAGER SIGNATURE	19. DATE APPROVED

Scan and email additional unit request form:

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