Washington State
Department of Social
& Health Services
Transforming lives

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

PROVIDER NAME	PROVIDER NUMBER	URBAN DESIGNATION **Choose one.**	DATE

Client Specific Add-On		

CLIENT NAME	START DATE	TOTAL HOURS REQUESTED

TOTAL HOURS REQUESTED (FOR SECOND MONTH, IF APPLICABLE)	OHS ONLY: TOTAL HOURS REQUESTED (FOR THIRD MONTH, IF APPLICABLE)	ESTIMATED ENDING DATE (MAXIMUM OF 60 DAYS (90 DAYS FOR CHILDREN'S RESIDENTIAL SERVICES) FROM START DATE)

REASON / JUSTIFICATION FOR REQUEST:
Provide an explanation of the circumstances requiring the need for additional staff and the anticipated length of the need, including an explanation of how the amount was determined (i.e. hours per day or do the hours vary depending on the day, weekends vs. weekdays).

Request must be submitted and approved by DDA prior to vendor providing additional staffing.

Emergency: ☐ Yes ☐ No

DDA Resource approval by: ; date:

Type: **Choose one.**

Comments:

PROVIDER SUBMITTING	DATE

Completed by DDA Resource Manager (RM)		

TOTAL HOURS APPROVED	FUNDING SOURCE **Choose one.**	SERVICE CODE (SERVICE CODE DATA SHEETS) **Choose one.**

COMMENTS

HOURS	RATE (FOR CURRENT RATES, GO TO DDA RATES (WA.GOV)	TOTAL
OHS ONLY		

RM REVIEWING	DATE

RM SUPERVISOR'S SIGNATURE	DATE

☐ Approve   ☐ Deny   ☐ Approve with Changes

COMMENTS

AMOUNT AUTHORIZED	DATE AUTHORIZED	RM INITIALS

COPY TO: Client File, Provider, DDA RM