

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Staff Add-on Request for Client Specific Need

		P	ROVIDER NUMBER	URBA	N DESIGNATION	DATE
				Cho	ose one.	
		Client S	pecific Add-On			
CLIENT NAME			START DATE		STIMATED END DA	
				1)	MAX: 90 DAYS FRO	OM START DATE)
TOTAL HOURS REQUESTED MONTH)	(FOR FIRST	TOTAL HOURS RE	QUESTED (FOR SECON		OURS REQUESTED IF APPLICABLE)	D (FOR THIRD
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REASON / JUSTIFICATION FO	OR 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: ; Dat	e:				
Type: Choose one.						
Comments:						
DDO//IDED OUDLAITTING					DATE	
PROVIDER SUBMITTING				DATE		
				(514)		
Completed by DDA Resource Manager (RM) TOTAL HOURS APPROVED FUNDING SOURCE SERVICE CODE (SERVICE CODE DATA SHEETS)						
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COPY TO: Client File, Provider, DDA RM