DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Staff Add-on Request for Client Specific Need

PROVIDER NAME	PROVIDER NUMBER	URBAN DESIGNATION	DATE
		Choose one.	

Client Specific Add-On

CLIENT NAME	START DATE	ESTIMATED END DATE (MAX: 90 DAYS FROM START DATE)

TOTAL HOURS REQUESTED (FOR FIRST MONTH)	TOTAL HOURS REQUESTED (FOR SECOND MONTH, IF APPLICABLE)	TOTAL HOURS REQUESTED (FOR THIRD MONTH, IF APPLICABLE)

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	SERVICE CODE (SERVICE CODE DATA SHEETS)
	Choose one.	Choose one.

COMMENTS

SERVICE MONTH AND YEAR	AUTHORIZED HOURS	RATE (FOR CURRENT RATES, GO TO DDA RATES (WA.GOV)	TOTAL

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