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| C:\Users\Brian.Manubay\Desktop\DDDS Header.jpg | **Request for Exception Rate for Consultative Nursing Services** |

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| **General Information** | NAME OF INDIVIDUAL TO BE ASSESSED: | | | TODAY’S DATE: | |
| DATE OF BIRTH: | MCI#: | | COUNTY OF RESIDENCE: | |
| AGENCY SUBMITTING REQUEST: | | CONSULTING RN SUBMITTING REQUEST: | | SUPPORT COORDINATOR/CASE NAVIGATOR: |

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| **Requested Additional Hours** | PLEASE DETAIL THE REASON ADDITIONAL HOURS ARE NEEDED, INCLUDING SUMMARY OF SUPPORTING DOCUMENTATION: | |
| DATE DISCUSSED WITH TEAM AND IDENTIFY TEAM MEMBERS: | NUMBER OF ADDITIONAL UNITS/HOURS REQUESTED: |
| NUMBER OF AUTHORIZED UNIT/HOURS: | NUMBER OF UNIT/HOURS REMAINING FOR PCP YEAR: |

**After completing the above sections, email this request to the appropriate Regional Resource Mailbox:** [**DHSS\_DDDS\_Exceptions\_Sussex@delaware.gov**](mailto:DHSS_DDDS_Exceptions_Sussex@delaware.gov)**,** [**DHSS\_DDDS\_Exceptions\_Kent@delaware.gov**](mailto:DHSS_DDDS_Exceptions_Kent@delaware.gov)**,** [**DHSS\_DDDS\_Exceptions\_NCC@delaware.gov**](mailto:DHSS_DDDS_Exceptions_NCC@delaware.gov)

**At the end of the PCP year authorization will automatically return to originally authorized RN Consultative Support Hours as determined by the annual Assessment of Need for Clinical Nursing Services.**

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**FOR SUPPORT COORDINATOR/CASE NAVIGATOR TO COMPLETE:**

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| **Agreement Status** | REVIEWED BY (NAME/TITLE): | |
| Do Not Agree  Agree | DATE REVIEWED: |
| COMMENTS: | |

**FOR DDDS NURSE CONSULTATION PROGRAM ADMINISTRATOR TO COMPLETE:**

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| --- | --- | --- |
| **Approval Status** | Not Approved  Approved | NUMBER OF UNIT/HOURS APPROVED: |
| APPROVED BY (NAME/TITLE): | DATE APPROVED: |
| DATE SUPPORT CORDINATOR NOTIFIED & AUTHORIZATION SENT (IF APPLICABLE): | |
| COMMENTS: | |