Appendix A

DELAWARE HEALTH AND SOCIAL SERVICES Division of Developmental Disabilities Services	**Request for Additional Support Hours**

Name of Individual: _____ Name of Service Provider: _____ Date of Request: _____ Start Date Requested: _____ Name of Site/Home: _____	Type of Request: Check one: ☐ Residential ☐ Day Services Check one: ☐ New Request ☐ Extension ☐ Modification

*****If all fields are not completed, the request will not be processed*****

1. Please summarize why additional hours are being requested. Please include data points that are being tracked to support this request:

Name of Individual: _____ Name of Service Provider: _____ Date of Request: _____ Start Date Requested: _____ Name of Site/Home: _____	Type of Request: Check one: ☐ Residential ☐ Day Services Check one: ☐ New Request ☐ Extension ☐ Modification

2. What other interventions, supports or strategies have been tried?

3. How will additional support hours/units improve the situation?

Name of Individual: _____ Name of Service Provider: _____ Date of Request: _____ Start Date Requested: _____ Name of Site/Home: _____	Type of Request: Check one: ☐ Residential ☐ Day Services Check one: ☐ New Request ☐ Extension ☐ Modification

4. Number of ICAP support hours/units for the individual:

   _____

   a. Number of additional support hours/units being requested:

   _____

   b. Total number of support hours combined (ICAP hours + additional hours of support requested): _____

5. Total number of daily support hours/units for the group the individual is supported in at day program or work/entire household (please notate any other service recipient that is receiving 1:1 staffing so those hours are not counted as potential supports hours associated with this request): _____

   a. Staff/Individual ratio at Day Program/Work- _____

   b. Staff/Individual ratio first shift for entire household(Residential request only-please notate any other service recipient that is receiving 1:1 staffing so those hours are not counted as potential supports hours associated with this request): _____

   c. Staff/Individual ratio second shift for entire household (Residential requests only-please notate any other service recipient that is receiving 1:1 staffing so those hours are not counted as potential supports hours associated with this request): _____

   d. Staff/Individual ratio third (overnight) shift for entire household (Residential requests only-(please notate any other service recipient that is receiving 1:1 staffing so those hours are not counted as potential supports hours associated with this request): _____

6. For how long are the additional support hours expected to be needed? _____

7. Date the request was discussed by the team: _____

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8. Please list the names of the members of the team present for the discussion: _____
9. Date of the last person-centered planning meeting: _____

☐ **All necessary support documents are attached to this request (if supporting documents are not attached, this request will be returned un-processed).**

Please type your name:

_____

Your Signature: _____ Date: _____

Complete and save this form as a PDF and attach all supporting documentation. Send to the applicable regional mailbox:

New Castle County: DHSS_DDDS_Exceptions_NCC@delaware.gov
Kent County: DHSS_DDDS_Exceptions_Kent@delaware.gov
Sussex County: DHSS_DDDS_Exceptions_Sussex@delaware.gov

Appendix B

DELAWARE HEALTH AND SOCIAL SERVICES Division of Developmental Disabilities Services	**DDDS Use Only** **Exception Request Review Form**

Name of Individual: _____ Name of Service Provider: _____ Date of Request: _____ Start Date Requested: _____ Name of Site/Home: _____	Type of Request: Check one: ☐ Residential ☐ Day Services Check one: ☐ New Request ☐ Extension ☐ Modification

DDDS SC/EN/CN Authorization:

☐ Approved

☐ Approved w/revisions (list revisions below)

_____

☐ Not Approved (list reason(s) why)

_____

SC/EN/CN Signature _____ Date _____

*** Electronically submit completed **approved** forms to RPD for residential requests or to Regional Day Services Director for day requests in order for the request form and accompanying authorization to be completed and submitted to OBSS.***

RPD/Day Service Director Authorization:

_____ _____

RPD/Day Service Director Signature or Designee Date

Comments: