

**Form S106
Request for Review
Based on a Major Life Change**

Agency Use

Name of Individual Receiving Services:

Current Tier Level of Support:

Date of Last SIS Assessment:

Name Agency/DDO:

Name of Person Completing Form:

Requestor Phone Number:

The individuals named above is requesting that the BHDDH review committee reassess support needs due to the following Major Life Change (check all that apply):

An emergency/crisis in the Participant's living situation

Risk of losing living situation

Risk of life threatening incidents

Repeated incidents relating to the Participant or other Participants' health and safety

A new diagnosis of mid-stage organic brain syndromes

A new diagnosis of serious mental health condition

Development of new co-morbid conditions

Development of significant health or medical condition

Provide a description of the specific issue(s) that meet the criteria above. Attach an additional letter/narrative if more information is needed to describe specific issues:

Start Date
of Service:

End Date
of Service:

Hours per
week:

Specify the documentation you have submitted with this request to substantiate the Major Life Change:

Medical assessment (not more than 90 days old)

Nursing Care Plan (not more than 90 days old)

Psychiatric assessment (not more than 90 days old)

Current Behavior Support Plan or Safety Plan

Other (specify)

Signature of Individual:

Date:

Signature of Respondent:

Date:

SUBMIT This Form and Accompanying Narrative VIA SECURE EMAIL To: BHDDH.S109@bhddh.ri.gov