

STATE OF RHODE ISLAND



Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
DIVISION OF DEVELOPMENTAL DISABILITIES
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Exception Form: Whole Life Shared Living Arrangement (WLSLA)

Name of participant:

Name of actual/proposed contractor:

Name of provider agency:

Name of agency contact person:

Agency contact email address:

Agency contact phone number:

Name of State or external case manager:

Case manager email address:

Case manager phone number:

Service definition:

“A community-based service where people live together in a Whole Life Shared Living Arrangement (WLSLA). WLSLA contractors agree to spend most of their time (in lieu of traditional day supports) actively engaged in their community, participating in community events and making connections based on the personal goals established in the person’s Individualized Support Plan (ISP).”

Please use this form to request an exception to one of the following parameters for WLSLA:

- I. A WLSLA contractor must not work in a paid or volunteer job outside the WLSLA. If requested, arrangements in which the contractor works part-time or during hours that are compatible with the participant's support needs will be considered on a case-by-case basis.**

Please explain how the contractor will support the participant in reaching the daily living and community engagement goals in their ISP, despite the contractor working. Please be specific.

Does the contractor's outside work allow for flexibility in supporting the participant when and where the participant needs it? Please describe.

II. If the participant is working in a paid job 30 hours per week or more, they generally would not need the type of support provided in WLSLA.

If there are circumstances that would still make WLSLA a good option for the participant, please describe those circumstances. Please be specific.

When this form has been completed, please email it to steven.seay@bhddh.ri.gov. You may be contacted for further information. When a decision has been reached, the participant's Case Manager and the agency contact person will be notified.

Thank you!

BHDDH PERSONNEL ONLY

Reviewer name:

Request decision: Approved Denied

Reason for denial (if applicable:

Reviewer Signature:

Date: