FormS109 Participant Request for Additional Supports Above Service Tier Package Authorization

Name of Participant			
Support Coordination Agency:			
Name of Person Completing Form:			
Relationship to Participant:			
Agency/DDO Completing Form:			
Participant Current SIS Tier:	Date		
Current Residential Status:			
Type of Request: (Please Choose One)	New S109 Request Change from Current S109	Appeal	
Additional Services Requested Above Current Tier Package:	Community-Based Supports Residential Services Transportation Shared Living Other	Day Activities Professional Services Respite Supported Employment	
Temporary Tier Request (To Request Difference between Packages):			
Additional Quarterly Hours Requested:	Additional Days Per Week:	Additional Units Per Quarter	
Time Span for Funding:			

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Requested End Date:

Requested Start Date:

*****Please attach a summary sheet showing how requested additional funding was calculated.*****

Please use fields below when requesting additional services only

Service	Units Type 1	X Ra	te Total	
	Units	X Ra	te Total	
Service '		equested A	dditional Funding:	
	Please check to conf	irm you've atta	ched any of the supporting do	cumentation:
	Behavioral/Medical Plan (In Supported Employment: Ca	Detailing Why Ad cluding diagnosis areer Developmen	ditional Supports are Being Requeste t Plan, Job Form, and 3 Months of Jol RDER OR ISP WITH S109 REQUEST	b Coaching Notes
	explanation about each Service Tier Package au documentation noted be	service item che thorized is not selow is up to date	this form confirm the following: A cocked is included and indicates why afficient to meet needs. The addition, complete, and I am making the asorts in the current tier package.	the current nal provided
	Participant Signature:	Date:	Respondent Signature	Date

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

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