## 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 of Last SIS Assessment: |  |  |
| Current Residential Status: |  |  |  |
| Type of Request: (Please Choose One) | nt S109 O Appeal |  |  |
| Additional Services Requested Above Current Tier Package: | Supports $\square$ Day Activities <br>  $\square$ Professional Services <br>  $\square$ Respite <br>  $\square$ Supported Employment |  |  |
| Temporary Tier Request (To Request Difference between Packages): | Additional Days Per Week: | Additional Units Per Quarter |  |
| Additional Quarterly Hours Requested: |  |  |  |
| Time Span for Funding: | Date: | Requested | nd Date: |

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

Please use fields below when requesting additional services only


Service Type 1


Service Type 2


Total Requested Additional Funding:

Please check to confirm you've attached any of the supporting documentation:
$\square$ Progress Notes Medical, Psych., PT, OT
$\square \quad$ Current Supports Summary Detailing Why Additional Supports are Being Requested
$\square$ Behavioral/Medical Plan (Including diagnosis)
$\square$ Supported Employment: Career Development Plan, Job Form, and 3 Months of Job Coaching Notes
$\square \quad$ * DO NOT ATTACH A NEW PURCHASE ORDER OR ISP WITH S109 REQUEST*

By checking this box, the signatories on this form confirm the following: A detailed explanation about each service item checked is included and indicates why the current Service Tier Package authorized is not sufficient to meet needs. The additional provided documentation noted below is up to date, complete, and I am making the assertion that service delivery needs exceed the supports in the current tier package.

| Participant Signature: | Date: | Respondent Signature | Date |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
|  | $\square$ | $\square$ | $\square$ |

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

