ALABAMA DEPARTMENT OF MENTAL HEALTH

DIVISION OF DEVELOPMENTAL DISABILITY SERVICES

REQUEST FOR REGIONAL ACTION

DATEClick or tap to enter a date.

TO: RCS DIRECTOR/DESIGNEE Click or tap here to enter text.

FROM: CASE MANAGER Click or tap here to enter text.

WAIVER PARTICIPANT INFORMATION

NAMEClick or tap here to enter text.

ADDRESS: Click or tap here to enter text.

CASE NUMBER Click or tap here to enter text.

DATE OF BIRTH: Click or tap here to enter text.

PHONE NUMBER Click or tap here to enter text.

SERVICE REQUESTED

Click or tap here to enter text.**SPECIALIZED MEDICAL EQUIPMENT**

Click or tap here to enter text.**ENVIRONMENT ACCESSIBILITY ADAPTATIONS**

Click or tap here to enter text.**SPECIALIZED STAFFING**

Click or tap here to enter text.**POSITIVE BEHAVIOR SUPPORTS**

Click or tap here to enter text.**SUPPORT SERVICES NOT INCLUDED IN YEARLY PERSON-CENTERED PLAN**
Service: Click or tap here to enter text.

Click or tap here to enter text.**CHANGES IN STAFFING LEVELS FOR RESIDENTIAL PROVIDERS**

REQUEST JUSTIFICATION (Completed by the Support Coordinator)

Choose a building block.

NEEDED INFORMATION (Completed by the Regional Office)

Choose a building block.

☐ **APPROVED**

☐**DENIED**

RO COMMENTS:

Choose a building block.

________________________________   **__________________________**

RCS DIRECTOR/DESIGNEE   **DATE**