ALABAMA DEPARTMENT OF MENTAL HEALTH

DIVISION OF DEVELOPMENTAL DISABILITY SERVICES

REQUEST FOR REGIONAL ACTION

DATE_____ (1)

TO: RCS DIRECTOR/DESIGNEE_____(2)

FROM: CASE MANAGER_____(3)

WAIVER PARTICIPANT INFORMATION

NAME:_____(4)

ADDRESS: _____(5)

CASE NUMBER:_____(6)

DATE OF BIRTH: _____(7)

PHONE NUMBER_____(8)

SERVICE REQUESTED

_____SPECIALIZED MEDICAL EQUIPMENT (9)

_____ENVIRONMENT ACCESSIBILITY ADAPTATIONS (10)

_____SPECIALIZED STAFFING (11)

_____POSITIVE BEHAVIOR SUPPORTS (12)

_____SUPPORT SERVICES NOT INCLUDED IN YEARLY PERSON-CENTERED PLAN (13)

_____ CHANGES IN STAFFING LEVELS FOR RESIDENTIAL PROVIDERS (14)

REQUEST DOCUMENTATION (15)

NEEDED INFORMATION (16)

Date returned to CM_____(17)

_____ APPROVED (18)

_____DENIED (19)

RO
COMMENTS:__(20)_____

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_____(21) **_____(22)**

RCS DIRECTOR/DESIGNEE **DATE**