|  |  |
| --- | --- |
| C:\Users\Brian.Manubay\Desktop\DDDS Header.jpg | **Request for Exception Rate for Consultative Nursing Services** |

|  |  |  |
| --- | --- | --- |
| **General Information** | NAME OF INDIVIDUAL TO BE ASSESSED: | TODAY’S DATE:      |
| DATE OF BIRTH:      | MCI#:      | COUNTY OF RESIDENCE:      |
| AGENCY SUBMITTING REQUEST:      | CONSULTING RN SUBMITTING REQUEST:      | SUPPORT COORDINATOR/CASE NAVIGATOR:      |

|  |  |
| --- | --- |
| **Requested Additional Hours** | PLEASE DETAIL THE REASON ADDITIONAL HOURS ARE NEEDED, INCLUDING SUMMARY OF SUPPORTING DOCUMENTATION:      |
| DATE DISCUSSED WITH TEAM AND IDENTIFY TEAM MEMBERS:      | NUMBER OF ADDITIONAL UNITS/HOURS REQUESTED:      |
| NUMBER OF AUTHORIZED UNIT/HOURS:      | NUMBER OF UNIT/HOURS REMAINING FOR PCP YEAR:      |

**After completing the above sections, email this request to the appropriate Regional Resource Mailbox:** **DHSS\_DDDS\_Exceptions\_Sussex@delaware.gov****,** **DHSS\_DDDS\_Exceptions\_Kent@delaware.gov****,** **DHSS\_DDDS\_Exceptions\_NCC@delaware.gov**

**At the end of the PCP year authorization will automatically return to originally authorized RN Consultative Support Hours as determined by the annual Assessment of Need for Clinical Nursing Services.**

|  |
| --- |
|  |

**FOR SUPPORT COORDINATOR/CASE NAVIGATOR TO COMPLETE:**

|  |  |
| --- | --- |
| **Agreement Status** | REVIEWED BY (NAME/TITLE):      |
| [ ]  Do Not Agree [ ]  Agree | DATE REVIEWED:      |
| COMMENTS:      |

**FOR DDDS NURSE CONSULTATION PROGRAM ADMINISTRATOR TO COMPLETE:**

|  |  |  |
| --- | --- | --- |
| **Approval Status** | [ ]  Not Approved [ ]  Approved | NUMBER OF UNIT/HOURS APPROVED:      |
| APPROVED BY (NAME/TITLE): | DATE APPROVED:      |
| DATE SUPPORT CORDINATOR NOTIFIED & AUTHORIZATION SENT (IF APPLICABLE):      |
| COMMENTS:      |