

Developmental Disabilities Administration Request for Services of Short Duration

Last Name: _____ First Name: _____ Request Date: _____

Date of Birth (MM/DD/YYYY): ____ / ____ / ____ Social Security #: xxx - xx - ____

Resource Coordinator (RC): _____ RC Telephone #: _____

You or your family can submit a request independently and can also receive assistance to identify your service and support needs, service provider, etc. from one of the following: your resource coordinator, a LISS agency, or a licensed DDA Family and Individual Support Services provider.

What type of intervention services/supports are you seeking in order to address this risk?

<input type="checkbox"/> Individual & Family Counseling	<input type="checkbox"/> Attendant or Personal Care	<input type="checkbox"/> Day Care	<input type="checkbox"/> Specialized Equipment	<input type="checkbox"/> Health Services	<input type="checkbox"/> Respite Care	<input type="checkbox"/> Housing Adaptations	<input type="checkbox"/> Transportation
<input type="checkbox"/> Therapeutic Services	<input type="checkbox"/> Medical Equipment Purchase, Rental, or Repair	<input type="checkbox"/> Crisis Intervention & Follow-Up	<input type="checkbox"/> Barrier Removal	<input type="checkbox"/> Community Integration Services	<input type="checkbox"/> Employment Related Services	<input type="checkbox"/> Intervention Services	<input type="checkbox"/> Other – i.e. item or onetime payment

Please describe the specific service(s) or intervention(s) requested within the category identified.

Please describe how this intervention service/support will remediate the risk of crisis?

Request for Services of Short Duration

Service Request					
Please provide specific information related to the service provider, cost, frequency, duration, etc. If a provider has not already been identified please not "To Be Determined" or TBD.					
Service/Item	Details (if applicable)	Frequency of Service (if applicable)	Dates of Service (if applicable)	Cost of Service/Item	Service Provider Name, Address, Telephone #
<i>Example:</i> <i>Attendant Care</i>	<i>3 Hrs In home service on Saturdays from 8:30- 11:30 a.m.</i>	<i>Every Saturday for 8 weeks</i>	<i>February 1 – March 1, 2012</i>	<i>\$18 per hour</i> <i>Total Hours: 24</i> <i>Total Cost: \$432</i>	<i>ABC Agency</i> <i>123 Street</i> <i>Baltimore, MD 410-123-4567</i>
<i>Example:</i> <i>Family Counseling</i>	<i>Counseling Saturdays from 9 -11 a.m.</i>	<i>Every Saturday for 8 weeks</i>	<i>February 1 – March 1, 2012</i>	<i>\$100 per hour</i> <i>Total Hours: 16</i> <i>Total Cost: \$1600</i>	<i>FSS Agency</i> <i>444 G Street</i> <i>Baltimore, MD 410-333-4444</i>

Total Funds Requested: _____

Request Submitted By:

First and Last Name _____
Please Print

Telephone Number: _____ Email: _____

Relationship to person in the crisis prevention category: Self Parent Legal Guardian
 Resource Coordinators Other: _____