## D.M.R. INTENSIVE STAFFING REQUEST FORM

**CLIENT NAME __________________________ DATE OF REQUEST___________________**

**HOME:____________________________ NEW REQUEST or CONTINUANCE?___________**

### WHAT LEVEL OF INTENSIVE STAFFING SUPPORT IS BEING REQUESTED?

- [ ] ARM’S LENGTH
- [ ] LINE OF SIGHT

### PROPOSED INTENSIVE STAFFING HOURS

- [ ] 24 HRS/DAY
- [ ] WAKING HRS. ONLY
- [ ] DAY PROGRAM ONLY
- [ ] COMM EXP
- [ ] PM HOURS ONLY
- [ ] WEEKENDS

**OTHER (please give brief explanation):**

### PROPOSED INTENSIVE STAFFING ESTIMATED DURATION

- [ ] 2-3 MONTHS
- [ ] 3-6 MONTHS
- [ ] 6-12 MONTHS

**OTHER (please give brief explanation):**

### BRIEF STATEMENT OF NEED FOR INTENSIVE STAFFING:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

### WHAT ALTERNATIVES TO INTENSIVE STAFFING HAVE BEEN TRIED (e.g. environmental modifications, program changes, medications, etc.), AND WHAT WERE THE RESULTS? (Please include relevant data, outcomes; use additional paper if necessary)

______________________________________________________________________________

### RISK REVIEW CRITERIA (i.e. What are the behavioral criteria that would cause supports to be increased or decreased during the current review period):

______________________________________________________________________________
______________________________________________________________________________

### ADDITIONAL SUPPORT WILL PROVIDE THE FOLLOWING:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**SIGNATURE/TITLE OF PERSON MAKING THE REQUEST:**

**COPIES TO:**

PERSON MAKING ORIGINAL REQUEST
REGIONAL CHAIR OF INTENSIVE STAFFING REVIEW COMMITTEE
DIRECTOR OF PSYCHOLOGY
DIRECTOR OF HEALTH SERVICES
**REVIEW RESULTS**

**REGIONAL INTENSIVE STAFFING COMMITTEE RECOMMENDATION:**

RECOMMEND APPROVAL: YES______ NO ______, or

CONDITIONED APPROVAL RECOMMENDATION:
(Define)

(If not recommended state reason below)

Review Committee chairperson sign off______________________

**REGIONAL DIRECTOR REVIEW (recommendation*):**

APPROVAL (recommendation): YES______ NO ______, or

CONDITIONED APPROVAL (recommended):
(Define)

(If not approved state reason below)

Regional Director sign off______________________

**STATEWIDE COMMITTEE REVIEW:**

APPROVAL: YES______ NO ______, or

CONDITIONED APPROVAL
(Define)

(If not approved state reason below)

Statewide Committee chairperson sign off______________________

* If the proposed review involves new development over the funding cap or intensive staffing more that one year, the Regional Director will make a recommendation to the Statewide intensive Staffing committee for their review and action (approval etc.)