Hamilton County Developmental Disabilities Services

PROVIDER REVISION REQUEST FORM

Individual's Name		Provider		Today's Date	
Person Completing Form		Provider E-mail		Provider Phone #	
Span Start Date		Revision Effective **Start** Date		Revision Effective **End** Date	

Select a reason for the revision in section A, then complete the corresponding explanation section.
Revisions will be authorized for no more than 30 days prior to the receipt of a complete and accurate revision request.

A) Reason for revision

Section B: Change in residential schedule

NOTE: HCDDS Funding Department will determine if additional documentation and/or CPT meeting is required

Describe In Detail What Needs To Be Changed (i.e. "add 15 minutes to Wed. AM schedule")

Section C: Independent Provider request for OT

For IPs only. To be completed for any emergency OT worked. Will only be approved if emergency criteria are met AND request is received within 72 hours of the emergency.

Describe the emergency that occurred and the shift(s) worked as a result. Include the date and description of the emergency.

Section D: Re-determination paperwork not submitted on time

Select one option below.

☐ Household schedule or other worksheet is attached to this request

☐ CPT meeting is needed to set up services for the span (shared residential settings, PAs and anyone with 2:1 staff require a CPT)

Section E: ADA revision request

Select one below then provide details.

☐ Requesting current authorization be extended ☐ Requesting change in type of service authorized

Details of request

Section F: Other change requests

Use for changes to unscheduled HPC or drop-in HPC, HPC mileage, Shared Living, Meals, Respite, etc.

Explain why this change is needed for health and safety of the individual. What occurred in the individual's life?

Service/Billing Code	PAS Span	Units Authorized	Ratio	Request Units to Increase or Decrease	Total Units with Request

E-mail this form to: Revisions@hamiltonDDS.org for processing
TO BE COMPLETED BY HCDDS ONLY

☐ Approved ☐ Partial approval or approved with changes. **Explain:**

☐ Denied

SSA Signature: Date

SSA: *Approval can be e-mailed to Funding Dept. in lieu of signing*

CSDSL033

Revised 12/31/2019