



Disability Planning Organization of Kansas, Inc.
A Community Developmental Disability Organization Serving Kansans



TWIN VALLEY DEVELOPMENTAL SERVICES, INC.

REQUEST FOR EXTRAORDINARY FUNDING CHECKLIST AND FINDINGS

INFORMATION	Individual's Name:		Date of this Request:	
	Date of Birth:	SSN:	Initial Request: <input type="checkbox"/> For Service(s):	
	CDDO:		Cont. Request: <input type="checkbox"/> For Service(s):	
	TCM Provider for Individual:		Date of Initial EF for Residential Service(s):	
	Annual BASIS Completion Date:		Date of Initial EF for Day Service(s):	
	Tier Rate:		MFP: <input type="checkbox"/> Date of Initial MFP funding:	
Request submitted by Community Service Provider:				
Day Service:		Residential Service:		
CHECKLIST	<input type="checkbox"/>	Summary Page: page 2	<input type="checkbox"/>	Justification for Extraordinary Funding: page 7 (CDDO Screener completes)
	<input type="checkbox"/>	Equipment and Supplies Form: page 3	<input type="checkbox"/>	Person Centered Support Plan
	<input type="checkbox"/>	Direct Care Staffing Form: Day Services – pages 4A and 4B (if applicable)	<input type="checkbox"/>	Behavior Support Plan (if applicable)
	<input type="checkbox"/>	Direct Care Staffing Form: Residential Services – pages 4C and 4D (if applicable)	<input type="checkbox"/>	Summarized and interpreted behavioral data (if applicable)
	<input type="checkbox"/>	Average Hourly Wage Calculation Worksheet: page 5A and 5B OR payroll forms	<input type="checkbox"/>	Health Information (if applicable)
	<input type="checkbox"/>	Threshold Calculation Worksheet: page 6	<input type="checkbox"/>	Summarized health data with health care professional's recommendations (if applicable)
Interview	Requested Interview Date:		Requested Interview Time:	
			Location of Screening:	
	<i>CDDO Screener ONLY (Section Below)</i>			
	Date Application Received:	Date, Time, Location Approved	If not approved, Corrections made:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
FINDINGS (CDDO Screener completes this section)	Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No		Justification Level assigned:	
	Comments:			
ACKNOWLEDGEMENT	By completing this section, you acknowledge that you have reviewed the information as indicated on the checklist above, and findings as indicated above, and have no further information or additions.			
	Day Service Rep. Name:			Date:
	Residential Service Rep. Name:			Date:
	Case Management Rep. Name:			Date:
	CDDO EF Screener Name:			Date:
CDDO ONLY	Date:		Action:	
	POC Start Date:		Time Limits, if any:	
	Interim Recommendations:			
	Review Plan:			

