DEVELOPMENTAL DISABILITITIES ADMINISTRATION (DDA)

DDA Request for Additional Units
Nurse Delegation (ND)

1. RND NAME	2. RND TELEPHONE NUMBER	3. RND E-MAIL ADDRESS
4. CLIENT'S NAME		5. CLIENT'S DATE OF BIRTH
6. CASE MANAGER'S NAME	7. CASE MANAGER'S TELEPHONE NUMBER	8. CASE MANAGER'S E-MAIL
9. DDA NURSE DELEGATOR COORDINATOR'S NAME	10. COORDINATOR'S TELEPHONE NUMBER	11. COORDINATOR'S E-MAIL

12. I will need _____ more units in addition to the 100 units already authorized for the month of _____. This will allow me to bill for a total of _____ units for the month of _____.

13. Reason additional units needed (check all appropriate boxes below):

A. **For insulin,** complete the section below (no additional narrative required).

☐ Initial visit; _____ units needed.

☐ Supervisory visit; _____ units needed.

☐ New support providers / caregivers; _____ units needed.

Total number of caregivers delegated insulin: _____

B. **Other than insulin,** please list reason(s) units needed:

14. DATE REQUESTED	15. REQUESTING ND SIGNATURE	
16. UNITS APPROVED	17. ND / NURSE SERVICE PROGRAM MANAGER SIGNATURE	18. DATE APPROVED

Scan and email additional unit request form:

Doris Barret

Nursing Service Unit Manager

Barreda@dshs.wa.gov