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|  | 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. ACES ID NUMBER | 6. CLIENT’S DATE OF BIRTH | |
| 7. CASE MANAGER’S NAME | | | 8. CASE MANAGER’S TELEPHONE NUMBER | 9. CASE MANAGER’S E-MAIL | |
| 10. DDA NURSE DELEGATOR COORDINATOR’S NAME | | | 11. COORDINATOR’S TELEPHONE NUMBER | 12. COORDINATOR’S E-MAIL | |
| 13. 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 .  14. 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: | | | | | |
| 15. DATE REQUESTED | | 16. REQUESTING ND SIGNATURE | | | |
| 17. UNITS APPROVED | | 18. ND / NURSE SERVICE PROGRAM MANAGER SIGNATURE | | | 19. DATE APPROVED |
| **Scan and email additional unit request form:**  Erika Parada  Nursing Service Unit Manager  [Erika.Parada@dshs.wa.gov](mailto:Erika.Parada@dshs.wa.gov) | | | | | |