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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 ParadaNursing Service Unit ManagerErika.Parada@dshs.wa.gov  |