Pennsylvania Department of Public Welfare
Office of Developmental Programs

REQUEST for INCREASED NURSING STAFFING

ICF/MR Program

Check the correct box for the submission of this current request.

☐ **Request for increased services from existing services** ☐ **Requested Change in service**

Information—Please Print			
Provider Name	**Date of Request**	**Consumer initials**	**Service Location #**
How many people live at this site?	**MPI #** (9 digits) ☐☐☐☐☐☐☐☐☐		

List current staffing pattern. (By day list the number and types of worker per shift.(eg. Monday 7am-7pm, 5 DCW and 3 LPNs.)

Monday		**Saturday**	
Tuesday			
Wednesday		**Sunday**	
Thursday			
Friday			

If you have 8 or less people living at this site, has the unlicensed staff been trained to give medication?
YES ☐ **NO** ☐

Briefly describe all health conditions and current services and supports for the consumer prior to the new service request. NOTE: This can be included as attachment if space in limited.

ICF/MR Program

Provider's Name: _____ **MPI# (9 digits):** | | | | | | | | | |

Consumer initials _____

What has changed in the person's or person's health conditions that require a nurse or change in nursing services? (Please include specific information for each individual and their birth date and attach additional information justification information to this form.)

Time Requested			
Day of the Week	**Time Nursing Services Requested (e.g. 7:00 am to 10:00 am)**	**Requested Start Date (mm/dd/yyyy)**	**Anticipated Length of Need (months)**

Please return the completed form (page 1 and 2) to the Office of Development Programs, ATTN: Kathy Deans Health &Welfare Building, Room 411, PO Box 2675, Harrisburg, PA. 17105

For Office use only:
Date received by ODP:_____ Date action completed by ODP:_____
Comments:

Pennsylvania Department of Public Welfare
Office of Developmental Programs

REQUEST for DIRECT CARE STAFFING

ICF/MR Program

Check the correct box for the submission of this current request.

☐ **Request for increased services from existing services** ☐ **Requested Change in service**

Information—Please Print			
Provider Name	**Date of Request**	**Consumer initials**	**Service Location #**
How many people live at this site?	**MPI #** (9 digits) ☐☐☐☐☐☐☐☐☐		

List current staffing pattern. (By day list the number and types of worker per shift.(eg. Monday 7am-7pm, 5 DCW and 3 LPNs.)

Monday	**Saturday**
Tuesday	
Wednesday	**Sunday**
Thursday	
Friday	
If you have 8 or less people living at this site, has the unlicensed staff been trained to give medication?	**YES** ☐ **NO** ☐

Briefly describe all health conditions and current services and supports for the consumer prior to the new service request. NOTE: This can be included as attachment if space in limited.

ICF/MR Program

Provider's Name: _____ **MPI#** (9 digits): | | | | | | | | | |

Consumers initials: _____

What has changed in the person's or person's health conditions or supports that require a change in staffing. (Please include specific information for each individual and their birth date and attach additional information justification information to this form.)

Time Requested			
Day of the Week	**Time Support Services Requested (e.g. 7:00 am to 10:00 am)**	**Requested Start Date (mm/dd/yyyy)**	**Anticipated Length of Need (months)**

Please return the completed form (pages 1, 2and any attached sheets) to the Office of Development Programs, ATTN: Kathy Deans Health &Welfare Building, Room 411, PO Box 2675, Harrisburg, PA. 17105

For Office use only:

Date received by ODP:_____ Date action completed by ODP:_____

Comments:

7/28/09

GUIDELINES FOR COMPLETING THE REQUEST FOR INCREASED STAFFING

Page 1

Place a check in the appropriate box for the type of request. Check only ***one*** box per request.

INFORMATION

Print the provider full name.
Date of the request must be completed (mm/dd/yyyy).
Please provide the consumer's or consumer's initials that will require increased staffing.
Provide the service location number
Insert the number of people living at the site.
Enter the 9 digit provider MPI identification number.
Complete the table "List current staffing pattern. (By day list the number and types of worker per shift. e.g. Monday- Sunday, 2 direct care workers from 7-3.)
Answer the question, if you have 8 or less people living at this site, has the unlicensed staff been trained to give medication?

DESCRIBE All CURRENT HEALTH CONDITIONS AND CURRENT SERVICES AND SUPPORTS FOR THE CONSUMER PRIOR TO THE NEW SERVICE REQUEST.

Give a narrative description of each of the consumer's diagnoses, current treatment and procedures, medications, equipment/supplies, etc. that are used for his/her daily 24 hours care. Please include their birth date. You may use attachments if this space is not adequate for completing the documentation.

Page 2

Fill in the consumer initials, provider name and MPI number at the top of the page.

WHAT HAS CHANGED IN THE PERSON'S HEALTH THAT REQIRES A NURSE OR CHANGE IN NURSING SERVICES?

Please describe the changes and include specific information for each individual and attach additional information justification information to this form. Documentation must include sufficient information regarding the care, treatments, procedures, supplies, equipement, that are needed to support the **increase** in staffing. Indicate when you need the additional support based on physician orders and medical condition of the consumer. This information should be included in their updated ISP (treatment plan).

TIME REQUESTED

Please complete the table noting the day of the week, by listing the day and the hours nursing is needed and then fill in the block for the anticipated length of time in months that nursing will be needed.

Complete the request by signing the form and mailing the completed form and accompanying documentation to Kathy Deans at the address listed.