

V. Extraordinary Care (Check all that apply and provide explanation.)		
<input type="checkbox"/> Inability to locate or hire staff <input type="checkbox"/> Staff are not able to provide the needed supports <input type="checkbox"/> Spouse has a unique ability to care for the participant (special skill, training, license, etc.) <input type="checkbox"/> Other (explain below)		
Provide a detailed explanation for the selection(s) above:		
VI. Proposed Spouse to be the DSW		
Name of Spouse/Proposed DSW:		
DOB:		
Describe any licenses, certifications and/or special training pertaining to the care of the participant:		
VII. Acknowledgement		
By signing below, I acknowledge that the information and justification provided on this request form is accurate.		
DSP Representative/SD Employer Printed Name:		
DSP Representative/SD Employer Title:		
DSP Representative/SD Employer Signature:		
Date Signed:		
VIII. OAAS Service Review Panel (SRP) Review and Decision		
Additional Information Requested (if applicable):		
Date:		
<input type="checkbox"/> Request Approved	Date:	
<input type="checkbox"/> Request Denied	Date:	