

Developmental Disabilities Supports Division (DDSD) Regional Office Request for Assistance – RORA
This is not an incident report form. Submission of this form does not constitute reporting as required by regulation.

☐ Individual Level ☐ Provider Level ☐ Systemic Level

Request Date: _____ Name of Individual: _____ SS#: _____ - _____ - _____ DOB: _____

☐ Jackson Class Member ☐ Non-Jackson Class Member ☐ DD Waiver ☐ SGF ☐ Mi Via WaiverManaged Care Organization: ☐ Blue Cross Blue Shield ☐ Molina ☐ Presbyterian ☐ United Healthcare

Diagnosis/Condition: _____

Type of Service & Provider Agency (ies):

Regional Office: _____ County: _____

Box A – Contact Information:			
Submitted By (Name):		E-mail:	
Title or Relationship to Individual:		Phone:	Fax:
Case Management Agency:		Case Manager Name:	
		Phone:	Fax: email:

Box B – Check Appropriate Box Related to Primary Concern:		
<input type="checkbox"/> Budget/Billing	<input type="checkbox"/> Individual Service Plan	<input type="checkbox"/> Meaningful Day/Customized Community Supports
<input type="checkbox"/> Failure to provide Documentation	<input type="checkbox"/> ISP/QA needed	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Freedom of Choice	<input type="checkbox"/> Training	<input type="checkbox"/> Nursing
<input type="checkbox"/> Guardianship	<input type="checkbox"/> Speech Language Pathologist*	<input type="checkbox"/> Transition
<input type="checkbox"/> Health Care Planning (HCP, MERP, CARMP issues)		<input type="checkbox"/> Other _____
<input type="checkbox"/> Durable Medical Equipment (DME)*	<input type="checkbox"/> Behavioral Support*	<input type="checkbox"/> Medical Specialists*
<input type="checkbox"/> Assistive Technology Devices (including Augmentative Communication)*		<input type="checkbox"/> Medical Supplies*
<input type="checkbox"/> Physical Therapy*	<input type="checkbox"/> Occupational Therapist*	<input type="checkbox"/> Dental*
<input type="checkbox"/> Quality of care/services		

***For Specialty Services, Applicable Timelines:** DME & Assistive Technology/Augmentative Communication devices: 150 days; DME repair/modification 60 days; Therapy assessments begin within 30 days of receipt of the FOC or 90 days of the need identified. Medical Specialist's appointments scheduled within 14 calendar days.

Box C – Issue/ Problem/Request: Provide description of issue to include the date identified. Include identified barriers and chronological list of actions taken to resolve this issue (attach supporting documentation):