 **Request for K Plan and OPI-M Ancillary Services**

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| Consumer’s name: | Consumer’s prime number: |
| Case manager’s name: | Branch number: |
| Approving manager’s name: | Date: |
| Bids are attached:  Yes  No | Pictures are attached:  Yes  No |
| This request is for a consumer receiving OPI-M services: | Yes  No |

**Service Type:**

Electronic back-up systems and assistive technology OAR 411-035-0030

Chore service OAR 411-035-0040

Environmental modifications (*over $500 must be completed by licensed contractor*) OAR 411-035-0055

Consumer transition services, any type, if over financial limits specified in rule OAR 411-035-0070

Describe the reason the service is necessary, the assessed need that will be met and the expected outcome for the individual.

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Submit this form and all documentation to: [KPlan.Requests@dhsoha.state.or.us](mailto:KPlan.Requests@dhsoha.state.or.us)