Connecticut Department of Children and Families
AUTHORIZATION: ONE-TO-ONE THERAPEUTIC SAFETY STAFFING
DCF-383A
1/19 (Rev.)

Agency Name:	Program Name:			Program LINK #:
Address: (No. and Street):	City:	State: CT	Zip:	Phone:

SECTION I – CHILD IDENTIFYING DATA

Child LAST Name	Child FIRST Name	Link#:	DOB:	Gender: Select One or enter your own
Race: Please Select One	Ethnicity: Please Select One			Primary Language: Please Select One
Reason for One-to-One Request:			Date of Admission:	Child's IQ:
Placement Prior to Admission:			Child's Height: Ft. Inches	Child's Weight:
SW LAST Name:	SW FIRST Name:	SW E-mail:		SW Phone:
DCF Office: Select DCF Office			Child's DCF Status: Please Select One	

SECTION II – ONE-TO-ONE STAFFING AUTHORIZATION DATA

Complete the information below for each one-to-one staffing request: ☐ initial authorization request ☐ re-authorization request

1. For the initial authorization request only, attach a clinical summary that includes a description of the child's current mental status, behavior and functioning, as well as information about any relevant history and/or current stressors that would justify the need for one to one staffing. The authorization request cannot be reviewed without this summary.
2. For the re-authorization request only, identify the number of previously approved re-authorizations: _____
3. The work title of the staff that will be providing the one to one services: _____
4. Agency status of the staff that will be providing the one to one staffing (e.g. full time child care staff, child care relief staff, outside agency child care staff, etc.):

SECTION III – ONE-TO-ONE STAFFING PROVIDED AND AGENCY AUTHORIZATION

Dates, shifts and hours one-to-one staffing must be provided (Attach a daily schedule)			
Total hours per day one-to-one staffing will be provided:	Hourly rate of One-to-One Staffing		
Name of Agency/Program Administrator requesting payment authorization	Signature of Agency/Program Administrator requesting payment authorization	Title	Date:

SECTION IV – DCF AUTHORIZATION FOR PAYMENT

Authorization Not Valid Without Both Agency/Program and DCF Signatures. This Authorization Is for A Maximum Of 72 Hours Within a 10 Day Period, UNLESS a DCF Administrator or his/her designee has granted a waiver for a monthly re-authorization and has signed this form.

☐ Payment is Authorized

☐ Payment is NOT Authorized:

☐ A Waiver for Monthly Re-Authorization has been Granted

Remarks / Reasons:

Name of DCF Staff making payment authorization (waiver) decision:	Signature of DCF Staff making payment authorization (waiver) decision:	Title of DCF staff	Date: