



Creating solutions, *One* person at a time®

Innovations

**Relative/Legal Guardian as Direct Support Employee Policy
Part C Reconsideration Request**

NOTE: To be completed by the Provider Agency or Employer of Record

Today's Date: _____ Date of Denial: _____

Innovations Participant Name: _____

Name and Contact of Provider Agency or Employer of Record:

Prospective Employee: _____

Relationship to Consumer: _____

Please provide a narrative description below to offer clarification or additional information regarding the **Part C Request** to exceed hours/daily units per week.

NOTE: No other documentation will be accepted or considered (i.e. Dr.'s Notes, letters from parents etc.).

The description must be typed

[Empty rectangular box for typed description]

Provider Agency Qualified Professional, Employers of Record, Managing Employers
Signature, Title and Date

NOTE: This form must be received within thirty (30) days of the date of the letter of denial or the request will not be accepted. After thirty (30) days the denial is final and cannot be reconsidered. Requests submitted after the deadline will not be reviewed.

Please remit Reconsideration Request to the following address within thirty (30) days of the denial to:

PBH Reconsideration Committee
Administrative Assistant
4855 Milestone Avenue
Kannapolis, NC 28081