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| REGIONAL CENTER: |  |
| VENDOR NAME: |  |
| VENDOR NUMBER: |  |

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| Please describe why and how the concept is necessary for the vendor to come into compliance with the settings requirement.  |
|  |
| Please describe any potential challenges this vendor might have in implementing this concept. |
|  |
| If the vendor has received other funding from DDS, including HCBS, disparity funding or CPP funding, please comment on how the vendor used the funds and met or did not meet the funding expectations. Please also comment on the uniqueness of this request relative to any prior funding received. Mark N/A if no prior funding received. |
|  |
| Please mark whether you recommend or do not recommend the concept and describe your rationale. |

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| --- | --- | --- | --- |
| Recommend: |  | Do not recommend: |  |

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| Rationale: |
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