OFFICE OF COMMUNITY DEVELOPMENT
Community Placement Plan and Community Resource Development Plan

ATTACHMENT D

MODIFICATION REQUEST FORM

MAIN INFORMATION	
1. Date of Request	
2. Regional Center (RC)	
3. Project ID	
4. Development Type	
5. Total Bed Counts	
6. Indicate Adult, Children, or Elderly	
7. Name of Housing Developer Organization (HDO)	
8. If Non-HDO (check box)	☐
9. Name of Provider (if applicable)	
10. Type of Request (check box)	☐ Renovation (Complete Section 1) ☐ Holding Cost (Complete Section 2) ☐ Provider Fund (Complete Section 3) ☐ Bed Release (Complete Section 4) ☐ Others (Complete Section 5)

Section 1: RENOVATION FUNDING REQUEST			
1. Total Replacement Reserve Amount for This Home			
2. Total Replacement Reserve Amount for All Homes			
3. Requesting Amount			
4. Reason for the Request (provide details including justifications and attach supporting documents as necessary)			
5. Bids Information (renovations exceeding $15,000 per-item, submit minimum of two itemized bids)			
Item #1 Description			
Bid 1 Amount		Bid 2 Amount	
Item #2 Description			
Bid 1 Amount		Bid 2 Amount	
Item #3 Description			
Bid 1 Amount		Bid 2 Amount	
Item #4 Description			
Bid 1 Amount		Bid 2 Amount	
Item #5 Description			
Bid 1 Amount		Bid 2 Amount	
Item #6 Description			
Bid 1 Amount		Bid 2 Amount	

Section 2: HOLDING COST REQUEST			
1. Check If Holding Cost is Applicable to HDO	☐ Name of HDO:		
2. Check If Holding Cost is Applicable to Service Provider	☐ Name of Provider:		
3. Actual Service Date			
4. Current Monthly Holding Cost Amount			
5. Approved Holding Cost at Housing Acquisition Request (HAR)		Period (Month/Year)	Thru
6. Post HAR Holding Cost Approval (if any)		Period (Month/Year)	Thru
Post HAR Holding Cost Approval (if any)		Period (Month/Year)	Thru
7. Requesting Amount		Period (Month/Year)	Thru
8. Reason for the Request (provide details including justifications and attach supporting documents as necessary)			

Section 3: PROVIDER FUNDING REQUEST	
1. Funding Request for (check box)	☐ Current Provider ☐ New Provider
2. Name of Current Provider	
3. Name of New Provider	
4. Previously Approved Funding Amount (if any)	
5. Funds to be Returned by Previous Provider (if any)	
6. HDO Owned Home (check box)	☐ Name of HDO:
7. Non-HDO Home (check box)	☐ Name of Home Owner:
8. Requesting Amount	
9. Reason for the Request (provide details including justifications and attach supporting documents as necessary)	

Section 4: BED RELEASE REQUEST	
1. Name of the Individual	
2. Age	
3. Current Residence	
4. Release Which Bed Type?	
5. Reason for the Request (provide details including justifications and attach supporting documents as necessary)	
6. Provide a justification explaining why individuals currently prioritized within restrictive environments (e.g., PDC, CS, IMD) were not considered for the available bed(s)	

7. Current Approved Bed Designation and Counts

State Operated	Institutions for Mental Diseases	Community	Skilled Nursing Facility	Out-of-State

8. Information of Individuals Currently Residing in the Home

	Individual Name	Location Prior to Transition
State Operated Beds		
Institutions for Mental Diseases Beds		
Community Beds		
Skilled Nursing Facility Beds		
Out-of-State Beds		

Section 5: OTHERS (Development Type Change, Capacity Change, Address Change, etc.)	
1. Type of Request	
2. Reason and Justification for the Request (provide details including justifications and attach supporting documents as necessary)	