Branch:	Prime number:	Case name:
Worker name:		
Worker phone:	Worker email (if AAA):	

Request for AFH, RCF or ADS Exception

Services 1

Effective date: Most recent CA/PS date:

Request: Provider type:

Manager name: Manager email:

Community based care costs 2

Provider number: CAPS assessed rate: $

Provider name: Requested exception: $

Total: $

Summary 3

Please use the space below to summarize client service needs or to add additional information. You may include a separate sheet if necessary. Include the following:

- The reason for any increase or decrease in the service hours or level.
- Change in care setting or living arrangement.
- Additional information about service needs that may not be documented in CAPS.

E-mail to: spd.exceptions@state.or.us