Cuyahoga County Board of Developmental Disabilities
Independent Provider Emergency Overtime Authorization Request

Pursuant to 5123: 2-9-03 Provider will notify the Support Administrator <u>within 72 hours of the events</u> or circumstances creating the <u>emergency</u> and report the hours the provider worked that exceeded 60 hours in a work week (Sun – Sat).

Note: Known or planned events that necessitate a provider's hours to exceed the limit AND which meet the criteria in rule must be communicated to and approved by the Support Administrator in advance of those events. If you do not receive approval in advance from the Support Administrator for these hours, CCBDD will not authorize them retroactively. Email is the strongly preferred method of communication regarding these authorizations. This form is NOT to be used for those authorizations.

Person's Name: ______________________________ **Span Dates:** ______________________________

Provider Name: ______________________________ **Effective Requested Start/End Date:** ____________

Emergency Circumstance (describe): ____

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Total number of hours that exceeded 60 in a work week: ______________________________

Provider Signature: ___________________________ Date: ___________________________

Provider Phone Number: _______________________ Provider Email Address: _______________________

**Please email the completed form, requesting overtime approval, to the Support Administrator, as this will provide you with an electronic receipt.*

<u>CCBDD USE ONLY:</u>

SA Name (Print): ___________________________ SA Signature: ___________________________

Action Taken: ☐ Approved ☐Not Approved Date: ___________________________