Appendix I

SOR3 Exception Request

Date of Request:	**Provider Organization**:
Provider Staff:	**Provider Email**:
Client Identification Number:	**Provider Telephone** :

Exception Category:

☐ **Service cap increase** ☐ **Increase in client annual max**

☐ **Other (Describe):**

Exception Description:

Describe how this request is related to client's recovery:

Client's involvement in recovery (include any recovery supports received):

SOR2 funding received to date: $

Anticipated cost of request: $

Submit via email attachment to sor@idph.iowa.gov.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

For Iowa HHS Use Only

- ☐ Approved
- ☐ Returned for additional information
- ☐ Denied

Comments:

IHHS Signature: _____ Date: _____