

**Home and Community-Based Services (HCBS) Rules
REGIONAL CENTER RECOMMENDATION FORM**

REGIONAL CENTER:	
VENDOR NAME:	
VENDOR NUMBER:	

Please confirm the provider reported to be out of compliance in the self-assessment.	
Please describe any potential challenges this vendor might have in implementing this concept.	
If the vendor has received other funding from DDS, including HCBS, service access and equity 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.	
Recommend:	Do not recommend:
Rationale:	