



State of Connecticut  
Department of Developmental Services



Dannel P. Malloy  
Governor

Jordan A. Scheff  
Commissioner

**DEPARTMENT OF DEVELOPMENTAL SERVICES  
REQUEST FOR CAPITAL IMPROVEMENT TO EXISTING  
COMMUNITY LIVING ARRANGEMENTS**

DATE

(A)

APPROVAL IS REQUESTED FOR THE CAPITAL IMPROVEMENT DETAILED BELOW AT:

Property Address (B)

Improvement Requested (C):

Description of Need (D):

Scope of Work (E):

Estimated Total Project Cost (F):     \$

Expense Incurred by: (check one)      Provider      CIL

Explanation of Cost Estimate (G):

**BID SUMMARY FORM**

Provider:

Date:

Address:

Project Location:

Number:

Description of Work:

Type of Contractor (General, Trade)

Contractors Requests to Submit Bids

	Date Received	Bid Amount

Contract Award To:

If exception to bidding process is requested, check reason:

Unable to solicit three bids

Urgency to complete work

Other:

If lowest bid is not selected, write justification for choice:

Remarks:

Prepared by:

Provider

Approved By:

Region

Property Address:

(H)

The undersigned acknowledge that this document does not constitute a contract for development of a property and further acknowledges that any payments by the State of Connecticut related to this property may only be made pursuant to Sections 17b-244 and 17a-228 of the General Statutes and the regulations promulgated thereunder.

PROPOSED BY:

PROPOSED BY:

Private Residential Provider

Development Staff/Property Developer  
(if Applicable)

\_\_\_\_\_  
Signature (Name) (I) (Date)

\_\_\_\_\_  
Signature (Name) (J) (Date)

Print/Type Name

Print/Type Name

Tel No.:

Tel.No.

REVIEWED BY:

AFTER CONSULTATION WITH:

\_\_\_\_\_  
Signature (Name) (L) (Date)  
Regional Director for Region  
Department of Developmental Services  
(Or Authorized Designee)

\_\_\_\_\_  
(Signature) (Name) (M) (Date)  
Commissioner  
Department of Social Services  
(Or Authorized Designee)

Print/Type Name

Tel.No:

APPROVED BY

\_\_\_\_\_  
(Signature) (Name) (N) (Date)  
Commissioner  
Department of Developmental Services  
(Or Authorized Designee)

By signing below, I hereby certify that this capital improvement project is considered by the Department of Developmental Services to be a required project for the health or safety of the residents as detailed in CGS 17b-244.

\_\_\_\_\_  
(Signature) (Name) (O) (Date)  
Commissioner  
Department of Developmental Services  
(Or Authorized Designee)