

COMMUNITY LIVING disABILITY SERVICES

Subject: **Supported Employment: Follow-up Services – Appendix A – Initial Request**

ADULT DISABILITY SERVICES

**DAY SERVICES - REQUEST FOR FOLLOW - UP SERVICES
PARTICIPANT APPLICATION – INITIAL REQUEST**

(To be submitted each time a new job commences)

Participant Name: _____	S.I.N _____
Address _____	Phone _____
_____	Postal Code _____

Agency Name: _____	Contact Person: _____
Address: _____	Phone: _____
_____	Date: _____

Employer Name: _____	Phone: _____
Address: _____	
Job Title _____	
Wages (gross hourly): _____	Average Weekly Hours: _____
Employment Start Date: _____	
Anticipated Duration of Job (if seasonal or temporary): _____	
Job Description/Duties: _____	

Describe anticipated nature/characteristics of Follow-up: _____

Projected number of billable days for Follow-up in current fiscal year (April 1 – March 31): _____

<u>Office Use Only</u>	Application Status
Eligibility verified by Community Service Worker: _____	Recommended # of days for Follow Up: _____
Reviewed and Endorsed by Regional Authority: _____	Date: _____
Approved by Divisional Office: _____	Date: _____
Authorized level of funding: _____	days X _____ per diem = _____

Date Issued:	January 1, 2019
Replacing:	November 15, 1998

**MANITOBA
FAMILIES**

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