

COMMUNITY LIVING disABILITY SERVICESSubject: **Supported Employment: Follow-up Services – Appendix B – Extension Request****ADULT DISABILITY SERVICES****DAY SERVICES - REQUEST FOR FOLLOW-UP SERVICES
PARTICIPANT APPLICATION – EXTENTION REQUEST
(TO BE SUBMITTED IN FEBRUARY FOR NEXT FISCAL YEAR)**

Participant Name: _____ S.I.N. _____

Agency Name _____ Phone: _____

Contact Person _____ Phone: _____

Job Title: _____

Wages (gross hourly): _____ Average Weekly Hours: _____

Employment Start Date: _____

Changes in Job Description/ Duties from previous year, if any: _____

Summary of Performance evaluation during the previous year: _____

Anticipated Nature/characteristics of Follow-up during next fiscal year: _____

Projected number of billable days for Follow-up in upcoming fiscal year (Apr1 – Mar 31): _____

Office use only

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: _____

Authorized funding level: _____ days x _____

Per diem = _____

SOCIAL WORKER:

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

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FAMILIES

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