REQUEST TO BILL ADDITIONAL OPWDD SEMP EXTENDED SERVICES

A provider agency MUST complete this form when a person is employed, and requires additional hours after the initial 200 Extended SEMP hours, within each enrollment year. The enrollment year (365 days) is based on the original enrollment date, or 7/1/15 if the person was enrolled prior to that date.

The SEMP Extended billing codes are: Extended SEMP – Individual (4792) and Group (4793), Extended SEMP Self-Directed, Agency Purchase – Individual (4761) and Group (4762), Extended SEMP Self-Directed, Self-Hire – Individual (4771) and Group (4772)

SEMP Agency:

SEMP Agency Requesting Extension: _____

SEMP Agency Provider Code: _____ DDRO: _____

SEMP Director Name: _____ SEMP Director E-mail: _____

Individual:

Last Name of Individual: _____ First Name of Individual: _____

TABS #: _____ SEMP Enrollment Date: _____

For OPWDD Central Office Only:

Approved (check one): Yes ☐ No ☐ Number of Hours Approved: _____

Approved Billing Start Date: _____ Last Date to Bill Approved Hours: _____

Reason for Approval:

- ☐ Individual is stable in employment, but has higher support needs
- ☐ Person requires temporary additional assistance to meet work standards
- ☐ To maintain current job
- ☐ Changes in job responsibilities
- ☐ Individual is pursuing a 2nd job
- ☐ Individual obtained a new job this year
- ☐ Best Interest of person
- ☐ Other: _____

Reason Not Approved:

- ☐ Need additional justification
- ☐ Work barriers not adequately addressed
- ☐ Job match does not seem appropriate
- ☐ Other: _____

OPWDD Signature: _____ Date Processed: _____

Approval Number: _____ Date Sent: _____

Additional SEMP Extended Services Request continued……..

Last Name of Individual: _____ First Name of Individual: _____

TABS #: _____ **Is the person funded by State SEMP (Non-HCBS Waiver)? ☐ Yes ☐ No**

Is the person currently employed? Yes ☐ No ☐ (IF NO, SUBMIT A SEMP INTENSIVE FORM NOT THIS FORM)

Are SEMP Services Self-Directed? Yes ☐ No ☐ If yes, which type? ☐ Self-Hire ☐ Agency-Purchase

Employer's Name: _____

Employer's Business Location (City/Town): _____

Hourly Wage: _____ Title: _____

List 4 job duties: _____

_____

Average number of hours worked weekly: _____ Date Job Began: _____

Average percentage of work hours that require job coaching on the job: _____

Is this an Integrated Work Setting? Yes ☐ No ☐ Is this a Group Placement? Yes ☐ No ☐

Is this job Temporary or Seasonal? Yes ☐ No ☐ If Yes, how many months scheduled per year: _____

Is employer satisfied with individual's performance? Yes ☐ No ☐

Does this job meet the individual's stated career goals? Yes ☐ No ☐

Has the individual asked for a new job to be developed? Yes ☐ No ☐

Have you discussed career options with this individual? Yes ☐ No ☐

Describe any accommodations and natural supports that assist the employee in this job position:

Describe what you are doing to assist the individual in achieving greater independence on this job and to address potential job retention challenges. How you have coordinated or will coordinate with other services (day hab/prevoc/community hab) to assist with job retention issues (if appropriate).

Additional SEMP Extended Services Request continued……..

Will additional SEMP Extended Services include job development? Yes ☐ No ☐

If Yes, was a formal Discovery completed? Yes ☐ No ☐ If yes, estimate the number of Discovery hours: _____

If Yes, describe the job development plan:

Billing Information:

**Can only approve up to 200 per request.*

Activities	Estimate the Hours per Activity					
	First 200 Hours Provided	1st Request - Projected Hours	Hours Provided	2nd Request - Projected Hours	Hours Provided	3rd Request - Projected Hours
Job customization and analysis						
Job coaching/training at the job site						
Skills training off the job site						
Communication with existing employer						
Meetings/planning/communication off the job						
Travel Training						
Travel Time without the individual						
Travel Time with the individual						
Documentation related to SEMP services						
Career planning or job development						
TOTALS:	**200**					
REQUESTED START DATE:	**1ST Request**		**2nd Request**		**3rd Request**	

Submitted By (Name): _____

Phone Number: _____ Date: _____

Return Processed Request to (Name): _____ **E-mail:** _____

Email this form to SEMP.PE.Billing.Requests@opwdd.ny.gov

These records must be kept for six years from the date the service was provided in accordance with 18 NYCRR subdivision 504.3(a).