REQUEST TO BILL OPWDD SEMP INTENSIVE SERVICES

A provider agency MUST complete this form, be authorized by OPWDD to bill SEMP Intensive services within each enrollment year (365 days), and the person is NOT employed when request is made. The 365 days (year) is based on the original enrollment date, or 7/1/15 if the person was enrolled prior to that date. If a person recently lost a job, in order to continue billing SEMP after the 45 days, a SEMP Intensive Request must be approved.

The SEMP Intensive billing codes are: Individual (4790) and Group (4791), SEMP Intensive Self-Directed Agency Purchase – Individual (4759) and Group (4760), SEMP Intensive Self-Directed Self-Hire – Individual (4769) and Group (4770)

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:

- ☐ Discovery has been completed
- ☐ Barriers to job development or retention have been addressed
- ☐ A specific job is pending
- ☐ Individual has a positive work history
- ☐ Best interest of the person
- ☐ Other: _____

Reason Not Approved:

- ☐ Work barriers not addressed yet
- ☐ Job development does not address employment barriers
- ☐ Formal Discovery is recommended
- ☐ Additional discussion and/or documentation requested: _____

Other: _____

Recommended Activities and/or Skill Development (*may be provided through Pathway to Employment, Employment Training Program (ETP), Community Prevoc, Day Habilitation, Community Hab, Clinical Supports, etc.*):

- ☐ Discovery
- ☐ Assess next steps to employment
- ☐ Assess skills and abilities
- ☐ Community situational assessments
- ☐ Medical or clinical supports
- ☐ Stress management skills
- ☐ Develop transportation resources
- ☐ Explore new career options
- ☐ Interpersonal skills

OPWDD Signature: _____ Date Processed: _____

Approval Number: _____ Date Sent: _____

Request to Bill SEMP Intensive Services 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 YES, SUBMIT A SEMP EXTENDED FORM NOT THIS FORM)

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

Are the hours being requested previously approved in the prior enrollment anniversary year and expired prior to completion? Yes ☐ No ☐ If Yes, how many hours were remaining from the prior request? _____

What was the Approved Request #: _____ Date Previously Approved: _____

How many hours are you requesting now: _____

If you are requesting hours previously approved in the prior enrollment anniversary year –YOU DO NOT NEED TO COMPLETE THE REST OF THE FORM EXCEPT THE LAST 3 QUESTIONS (Submitted by and Return Request to).

Was the person previously enrolled in the Employment Training Program (ETP)? Yes ☐ No ☐

Is there documentation on file that the person previously received ACCES-VR services? Yes ☐ No ☐

If No, which of the following applies:

☐ It was determined that based on the person's higher level of support needs and/or limited job experience, the Employment Training Program (ETP) was utilized and the OPWDD-ACCES-VR Letter of Agreement is on file.

☐ The agency has written documentation from ACCES-VR, which states that the supported employment services required by the person would be best provided by OPWDD at the time.

Last date the individual worked at a job that is integrated and earned minimum wage (or +): _____

Why was the job terminated? (Provide an explanation, laid off is NOT acceptable unless the business closed)

How long was the person employed at that job? _____

Approximate weekly hours worked: _____ Was this job seasonal/temporary? Yes ☐ No ☐

If the person recently lost their job, and was receiving SEMP Extended Services, during the following 45 days, estimate how many hours of each service have been provided? Check if N/A: ☐

Planning: _____ Discovery: _____ Job Development: _____

Request to Bill SEMP Intensive Services continued……..

COMPLETE THIS SECTION **ONLY IF THE PERSON HAS SECURED A JOB STARTING SOON:**

Is the person starting a job soon? Yes ☐ No ☐ If Yes, list the start date: _____
Business' Name: _____
Person's New Job Title: _____
How many Initial or Additional SEMP Intensive hours are you requesting? _____
What is the requested billing start date? _____

IF THE PERSON IS STARTING A NEW JOB SOON DO NOT COMPLETE THE REST OF THE FORM EXCEPT FOR THE LAST 3 QUESTIONS (Submitted by and Return Request to).

OPWDD SEMP Intensive services are primarily focused on Job Development and Intensive Job Coaching. While some Discovery-type services may be provided, these services are limited (unless other authorization is given) as OPWDD funds other services such as Pathway to Employment and Community Prevocational services, which focus on pre-employment activities and preparation for employment.

Has Discovery been completed? Yes ☐ No ☐ If yes, estimate how many hours of Discovery? _____

If Yes, within which services? ☐Pathway to Employment ☐ETP ☐Community Prevoc Other (List): _____

Briefly list the person's job history since SEMP enrollment date:

Business Name	Job Duties	Dates Worked	Reason for Leaving Job

What are the top **2 challenges to employment**? Describe what services and supports, progress or expectations and anticipated duration to address the challenges to employment?

1) List Work Challenge: _____

Services/Supports: _____ Expected Duration: _____

Progress/Expectations:

2) List Work Challenge: _____

Services/Supports: _____ Expected Duration: _____

Progress/Expectations:

Request to Bill SEMP Intensive Services continued……..

Services individual currently receives (check all that apply): ☐ Day Hab ☐ Community Prevoc ☐ Community Habilitation ☐ Residential ☐ Site-based Prevoc Other: _____

If OPWDD SEMP Intensive billing is authorized, briefly describe the plan for job development:

Type of Job(s): _____

Related Skills the Person Possesses: _____

Related Job/Volunteer Experience: _____

List 3 Businesses you intend to contact:

1)_____ 2)_____ 3)_____

Billing Information:

Is this an (check): ☐ **Initial** SEMP Intensive Billing Request (A) ☐ **Additional** SEMP Intensive Billing request (B)

A) Initial SEMP Intensive Billing Request (**do not** complete section B below) **Start Date Requested**: _____

B) Additional SEMP Intensive Billing Request (**Complete Sections B below**)

*B) **COMPLETE THIS CHART ONLY IF YOU ARE REQUESTING ADDITIONAL SEMP INTENSIVE BILLING.***

	Estimate the Hours per Activity	
Activities	**Hours Provided from Previous Request**	**Hours Projected for this Request**
Discovery/situational assessments		
Career planning		
Meetings/planning/communication with person and support team		
Job development		
Soft skills and job retention skills		
Travel training		
Transportation with the person		
Transportation without the person		
Documentation related to SEMP services		
TOTALS:		
REQUESTED START DATE:		

B) Summarize the plan for the Additional SEMP Intensive Billing services requested:

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).