A picture containing text

Description automatically generated(To be completed by the Service Provider and sent to the CSC no later than the 15th of the month in which the Service Plan expires)

Logo

Description automatically generated

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Member Name:** | Member name | | | | | |  | | | | | **PPL ID:** | | PPL ID | | |
|  | | | | | | |  | | | | |  | | | | |
| **Current Service(s)** *Mark all that apply to the listed provider* | | | | | | Pre-Voc | | | | | IL Skills (ILS) | | | | | Supported Employment (SE) |
|  | | | | | |  | | | |  | | | | | | |
| **Provider Name:** | Provider name | | | | | |  | | **Requested Effective Date:** | | | | | | Effective date | |
|  |  | | | | | |  | |  | | | | | | Can only start on the 1st of a month | |
| **Community Service Coordinator:** | | | CSC | | | |  | | **MCO Care Coordinator:** | | | | | | MCO CC/CM | |
|  | | |  | | | |  | |  | | | | | |  | |
| *What goals were achieved with the service(s) provided?* | | | | | | | | | | | | | | | | |
| Enter text | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| *How much time was used and how was it used?* | | | | | | | | | | | | | | | | |
| *# of hours used:* | | Hrs used | \*Please include any estimated time remaining prior to Service Plan expiration | | | | | | | | | | | | | |
| Enter text | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| *What goals still need to be addressed?* | | | | | | | | | | | | | | | | |
| Enter text | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| ***Provider Recommendation***  *Mark all that apply* | | | | | | | | | | | | | | | | |
| Pre-Voc Reauthorization  (Needs more hours) | | | | | IL Skills Reauthorization  (Needs more hours) | | | | | | | | Increase in Supported Employment hours  (in accordance with STEPS policy above 13.25 hours) | | | |
| *Please provide a description of the type of supports needed and the requested number of hours for the Service Plan.* | | | | | | | | | | | | | | | | |
| *# of hours needed* | | *Pre-Voc/ILS*: Hrs needed | | *SE*: Hrs needed | | | |  | | | | | | | | |
| Enter text | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Service Provider Signature |  | Date |  | MCO CC/CM Signature |  | Date |
|  |  |  |  |  |  |  |
| CSC Signature |  | Date |  | STEPS Program Manager Signature |  | Date |
|  |  |  |  | **\*Required for ALL** **Pre-Voc/ILS Reauthorizations** | | |