(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)



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**  |