TEXAS Department of Aging and Disability Services

Form 2430
September 2014-E

Medically Dependent Children Program

Employment Assistance and Supported Employment Authorization

Section A: Individual Information

Name	Medicaid No.	Individual Plan of Care (IPC) Period From: _____ To: _____
Primary Caregiver Name		
Mailing Address, City, State, ZIP Code	County	Area Code and Telephone No.

Section B: Provider Authorization

Provider Name	Contract No.	Authorization Begin Date
Mailing Address, City, State, ZIP Code	Units (hours) Authorized	Area Code and Telephone No.

Service Code and Provider Type for Home and Community Support Services (HCSS) Providers (check only one box per form):

☐ 54 – Employment Assistance ☐ 37 – Supported Employment

Typical week(s) based on individual's need for Employment Assistance and Supported Employment: _____ units for typical week 1 for _____ weeks
_____ units for typical week 2 for _____ weeks

Case Manager Comments:

The provider may only bill for units of respite delivered and must not exceed the units (hours) authorized.

Section C: Case Manager Signature and Information

Typed or Printed Name	Area Code and Telephone No.
Mailing Address, City, State, ZIP Code	Area Code and Fax No.

_____ Signature – Case Manager

_____ Date

Section D: Provider Response to Service Authorization

Provider Comments:

_____ Signature – Provider Contact

_____ Date

Section E: Service Authorization Cancellation

☐ Your service authorization is cancelled effective: _____

_____ Signature – Case Manager

_____ Date