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## **REQUEST TO PROVIDE COMMUNITY BASED PREVOCATIONAL SERVICES IN A LARGER GROUP OR MULTIPLE GROUPS**

**Complete this form or obtain PRIOR approval if either One or Both conditions apply:**

1. *One (1) staff member delivers community based prevocational services to a group size of more than eight (8) individuals at the same location and time.*
2. *Staff deliver community based prevocational services to more than (1) group at the same location and time.*

### **Check all that apply and Complete the Sections Listed:**

**Requesting a Group Size of more than eight (8) individuals (maximum group size 15) for Community Based Prevocational Services (Complete Sections 1, 2 and 4)**

**Requesting a Group Size of more than eight (8) individuals (maximum group size 15) for ONLY a hub for Community Based Prevocational Services. (Complete Sections 1, 2 and 4)**

**Requesting more than one (1) Group of eight (8) individuals at the same location and time for Community Based Prevocational Services. (Complete Sections 1, 3 and 4)**

## **SECTION 1**

**Name of Agency**

**Provider ID #**

**DDRO:**

**Contact Person:**

**Email Address:**

**Telephone Number:**

**Date of Request:**

**Community Based Prevocational Services Code(s):**

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## SECTION 2

### Requesting a Group Size of More than Eight (8) Individuals (maximum group size 15 individuals)

- A spreadsheet may be substituted and must contain all pertinent information below.

Name of Individual

Tabs ID #

Requested effective date:

Name of business(s) or organization(s) and address(s) where the prevocational service will take place.

1.
2.
3.
4.
5.

Requested Group Size

(Maximum 15 individuals)

**Explain why:**

- a) a higher level of support is no longer needed for the individual;

- b) the individual would benefit from being in a larger group.

**Explain how the requested group size will facilitate the individual's transition from Prevocational Services to obtaining competitive employment.**

## SECTION 3

### Requesting Multiple Groups of Eight (8) at Same Location at the Same Time

\*If there is more than ONE Community Based Prevocational location  
complete a SECTION 3 for EACH location.

Name of Individual(s) *(Attach a spreadsheet with TABS ID if more than 1 individual)*

Tabs ID #



Effective date:

Community Based Prevocational  
Program Code:

Name of business or organization and address where the prevocational services are provided.

Name:

Address:

Complete this weekly calendar for the number of people at this location at the same time.

#### Weekly Calendar

	SUN	MON	TUES	WED	THUR	FRI	SAT
# of OPWDD HCBS Individuals							
# of Individuals Without Disabilities (please estimate)							
# of Agency Supportive Staff for the individuals at this location							

Describe how multiple groups in one location can provide a true community experience for the individuals.

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## SECTION 4

**Must be submitted by the Provider Agency's Director, Manager or Supervisor of Prevocational Services**

Printed name

Title

Email address

Date

**PLEASE SUBMIT THE COMPLETED FORM TO:**

[PRE.VOC.GROUP.SIZE.REQUEST@OPWDD.NY.GOV](mailto:PRE.VOC.GROUP.SIZE.REQUEST@OPWDD.NY.GOV)

**For OPWDD Central Office Only**

Approved (check one):

Yes

No

Effective Date:

Expiration Date:

Approval Number:

OPWDD Signature

Date:

*Providers must retain a copy of this form for six (6) years if approval is granted.*

**Please note: If you have authorized new enrollments for community based prevocational service then this approval will include new enrollments in a larger group size and/or multiple groups through the expiration date.**