INDIVIDUAL EMPLOYMENT SUPPORTS OUTLIER REQUEST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1853 (10-2024)

Clear Fields

1. All fields must be typed; no handwritten requests will be accepted.
2. If multiple provider agencies are providing services complete a separate form for each provider.

Region	Provider Agency	
Client Name		Client Date of Birth
Annual Plan Date	Medicaid Number	Request Date

Person Initiating Request	Relationship to Client

Date Team Met to Determine Request

Team Members Involved:

Names	Agency	Function (example: Parent, P.T., Coordinator)

Refer to IES Outlier Policy for the information that MUST be included in the Person-Centered Service Plan. Complete section in its entirety.

Describe the Situation

Comments
Work Schedule of Individual
Describe the need requiring additional job coaching/DSP staff time
List specific job Tasks the job coach/DSP staff will be assisting with

Describe any identifiable triggers or precursors to the need of additional job coaching/DSP staff time
Describe any assessments that have been done to assess risk and the function for the additional job coaching/DSP staff time
Describe what supports and strategies have been attempted and why have they not been successful
Describe why current job coaching/DSP staff time is not sufficient
Other or Additional Information

Requested Additional Hours "Per Month" For IES Outlier

Hours/Month Allocated from SIS for IES	Individual Employment Supports Hours Requested	Length of Request
		☐ 6 Months ☐ 12 Months

Fading Plan

List the process the job coach will use to assess when the client is able to work independently and the timeline that these opportunities will be trialed.

To be completed by the Provider CEO, or designee

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Provider CEO/Designee Signature	Date

Submit completed request to: dhsddreq@nd.gov