## ATTACHMENT " "TO THE MEDICAID WAIVER SERVICES AGREEMENT FOR WAIVER SUPPORT COORDINATION BETWEEN AGENCY FOR PERSONS WITH DISABILITIES AND

This Attachment " "("Attachment") is to the Medicaid Waiver Services Agreement ("Agreement") between the Florida Agency for Persons with Disabilities ("APD") and ("Waiver Support Coordinator" or "WSC") dated .

Article I, Section A, Subsection 2 of the Agreement refers to **Attachment "** " which outlines the basic details of the approved dual employment plan. The information below pertains to the non-WSC position held.

Place of work:	Work Hours per Week:	
Description of		
<b>Duties:</b>		
How clients will		
contact WSC		
during working		
hours:		
How clients will		
contact WSC		
during non-		
working hours:		

If *any* portion of the approved dual employment plan shall change, including details not outlined within this attachment, a revised plan shall be provided to the Regional office within 10 days of the change for review. I understand that changes to the current approved employment plan may result in denial of dual employment. Once the Agency makes a determination a revised *Attachment* " shall be executed and will supersede any previously approved dual employment plan.

By signing this Attachment, I am certifying that all information herein is true and correct and I agree to the terms set forth within Attachment " "of this Agreement. ("Qualified Organization") must attest to the information contained within this Attachment.

The employment plan may be terminated by either party without cause, upon no less than 30 calendar days' notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both

This Attachment is hereby incorporated into and m	nade a part of the Agreement.
WAIVER SUPPORT COORDINATOR:	STATE OF FLORIDA AGENCY FOR PERSONS WITH DISABILITIES
Printed Name	Printed Name
Signature	Signature
Date	Date
Medicaid Provider ID:	
QUALIFIED ORGANIZATION AND EMPLOYER O THAT I HAVE READ AND UNDERSTAND TH ATTACHMENT " OF THIS AGREEMENT.	THE DESIGNATED REPRESENTATIVE OF THI F THE WSC REFERENCED ABOVE, I ACKNOWLEDGI E DUAL EMPLOYMENT PLAN REFERENCED IN
QUALIFIED ORGANIZATION AND EMPLOYER O THAT I HAVE READ AND UNDERSTAND TH	F THE WSC REFERENCED ABOVE, I ACKNOWLEDGE
QUALIFIED ORGANIZATION AND EMPLOYER O THAT I HAVE READ AND UNDERSTAND TH ATTACHMENT " " OF THIS AGREEMENT.  QUALIFIED ORGANIZATION:	F THE WSC REFERENCED ABOVE, I ACKNOWLEDGE
QUALIFIED ORGANIZATION AND EMPLOYER OF THAT I HAVE READ AND UNDERSTAND THE ATTACHMENT " OF THIS AGREEMENT.  QUALIFIED ORGANIZATION: (Official Representative)	F THE WSC REFERENCED ABOVE, I ACKNOWLEDGE
QUALIFIED ORGANIZATION AND EMPLOYER OF THAT I HAVE READ AND UNDERSTAND THE ATTACHMENT "OF THIS AGREEMENT.  QUALIFIED ORGANIZATION: (Official Representative)  Printed Name	F THE WSC REFERENCED ABOVE, I ACKNOWLEDGE

parties. Said notice shall be delivered by certified mail, returned receipt requested, or in person with proof

WSC Dual Employment MWSA Attachment APD Form 65G-14.004 A Effective 7.1.2021

of delivery.