ATTACHMENT **“ ”** TO THE
MEDICAID WAIVER SERVICES AGREEMENT
FOR WAIVER SUPPORT COORDINATION
BETWEEN
AGENCY FOR PERSONS WITH DISABILITIES
AND
Enter WSC Name Here

This Attachment **“ ”** (“Attachment”) is to the Medicaid Waiver Services Agreement (“Agreement”) between the Florida Agency for Persons with Disabilities (“APD”) and Enter WSC's Name Here (“Waiver Support Coordinator” or “WSC”) dated Enter effective date of MWSA.

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 Duties:			
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. Enter QO Name Here (“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

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

This Attachment is hereby incorporated into and made a part of the Agreement.

WAIVER SUPPORT COORDINATOR:	STATE OF FLORIDA AGENCY FOR PERSONS WITH DISABILITIES
Enter WSC Name Here Printed Name	Printed Name
Signature	Signature
Date	Date
Medicaid Provider ID**:**	

BY SIGNING THIS AGREEMENT, AS THE DESIGNATED REPRESENTATIVE OF THE QUALIFIED ORGANIZATION AND EMPLOYER OF THE WSC REFERENCED ABOVE, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE DUAL EMPLOYMENT PLAN REFERENCED IN ATTACHMENT " " OF THIS AGREEMENT.

QUALIFIED ORGANIZATION:
(Official Representative)

Printed Name

Signature

Position

Date