NOTIFICATION OF CHANGE FROM SPECIALIZED SUPPORTIVE SERVICES PROVIDER

TO:	**GSW/CCM/RCM:**	**File Number:**	**GAIN Regional/REP Office:**
	Address:		
FROM:	**Treatment Services Provider:**		
	Address:		
	Provider Staff Person:	**Telephone Number:**	**Date:**

PARTICIPANT INFORMATION

Participant Name:	**Case Number:**	**GAIN Activity:**

SECTION A – PARTICIPANT ABILITY TO PARTICIPATE IN WtW ACTIVITIES/EMPLOYMENT

☐ Number of participation hours per week has increased to ____________hrs per week.

☐ Number of participation hours per week has decreased to ____________hrs per week.

SECTION B – CONCURRENT PARTICIPATION IN OTHER WtW ACTIVITIES/EMPLOYMENT

☐ Participant is now able to participate in other WtW activities in addition to treatment services for __________hrs per week.

☐ Participant is no longer able to participate in other WtW activities in addition to treatment services.

SECTION C - SUPPORTIVE SERVICES NEEDS

Participant needs assistance with: ☐ Child Care ☐ Transportation

☐ Work Related/Ancillary Expenses. Explain: ____

SECTION D - COMMENTS

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