

Texas Home Living Program (TxHmL)  
Home and Community-based Services (HCS)  
**Request for Variance of Supported Employment – Employer Requirements**

Individual Name (as reported in CARE system)		
Medicaid ID No.	CARE ID No.	
Provider Name		
Component Code	Vendor No.	
Waiver Type	Date of Enrollment	
Date of Individual/LAR Request to Continue Supported Employment (SE) from Provider	Was Individual Employed in an SE Position by Program Provider at Enrollment? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe Supported Employment Position		
Describe Specific Supported Employment Services Currently Provided and Frequency of Services		
Name and Title of Person Requesting Variance		Date
Email Address	Telephone No. (include Area Code)	Fax No.

**For DADS Use Only**

Approved Date	Disapproved Date
Comments	
Reviewer	Expiration Date of Variance