

Participant Name:	Maxis#	SS#:
Financial Worker:	Emp Counselor Name:	Agency:

**The Following Section is completed by Agency Manager/Supervisor.
 All Extension Decisions must be communicated to Ramsey County FAS via Laserfiche or
 Status Update sent to FAS Fax: (651)266-3930 or FAS email: fas.forms@co.ramsey.mn.us**

Extension Categories

All categories listed below that apply to this applicant are checked and the primary extension category is circled.
Note: The number listed after the extension is the corresponding Local Flag on Workforce One and the Maxis code entered on the TIME panel.

Please check one that applies:

- Initial Extension Decision**
 Post 60 Month Application
 Category Change
 Extension Review

Current Extension (if applicable):

<p><u>Hard to Employ</u></p> <p><input type="checkbox"/> Unemployable (5)</p> <p><input type="checkbox"/> IQ<80 (6)</p> <p><input type="checkbox"/> Learning Disabled (7)</p> <p><input type="checkbox"/> Mental Retardation (11)</p> <p><input type="checkbox"/> Mental Illness (12)</p> <p><u>Employed</u></p> <p><input type="checkbox"/> One parent employed 25+ hours/week (8E)</p> <p><input type="checkbox"/> One parent employed/Reduced hours (8F)</p> <p><input type="checkbox"/> Two parent employed 55+ hours/week (9)</p> <p><u>Other</u></p> <p><input type="checkbox"/> Ext due to Appeal only (AP)</p> <p><input type="checkbox"/> No extension identified (NO)</p> <p><input type="checkbox"/> Client has not provided documentation (NO)</p>	<p><u>Ill/Incap</u></p> <p><input type="checkbox"/> Participant Ill/Incap>30 days (1)</p> <p><input type="checkbox"/> Participant needed in the home (2)</p> <p>Needed for: (person's name) _____</p> <p><input type="checkbox"/> Family Violence (10)</p> <p><u>Ill/Incap – Special Medical</u></p> <p>Enter person's name who is eligible for spec med criteria</p> <p><input type="checkbox"/> PCA Services (3A) - _____</p> <p><input type="checkbox"/> Waivered Services (3B) - _____</p> <p><input type="checkbox"/> SED Child (3C) - _____</p> <p><input type="checkbox"/> SPMI Adult (3D) - _____</p> <p>Date of Diagnosis for possible Banked Months _____</p>
Extension to be reviewed in: <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> Other _____	
Next Review Date: _____	
<p><u>Comments</u></p> 	

EXTENSION APPROVAL

Date of Extension Decision:	Extension Review Team Member:
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