

EMPLOYMENT STABILITY PLAN

Date: Click here to enter a date.

SUPPORTED EMPLOYEE INFORMATION

General Information

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Date of Birth: | PIN: |
| Social Security Number: | Medicaid Number: |
| Street: | City: |
| State: | Zip Code: |
| Telephone: | Email: |
| Emergency Contact Name: | Emergency Contact Telephone: |
| Highest Level of Education: Choose an item. | |
| Date Education Completed: | Date Education Completed: Unknown: |

Legal Representative for APD Services

*If the supported employee is their own legal representative, select “Yes” from drop-down list and complete the “Legal Rep First Name” and “Legal Rep Last Name” fields. Omit the remaining questions. If someone else serves as the Legal Representative over governmental (APD) services, select “No” and then complete all the remaining fields for that person.*

|  |  |
| --- | --- |
| Is Employee their own Legal Representative? Choose an item. | |
| Legal Rep First Name: | Legal Rep Last Name: |
| Street: | City: |
| State: | Zip Code: |
| Telephone: | Email: |

IMPLEMENTATION PLAN (SUPPORTED EMPLOYEE’S GOALS, OUTCOMES, AND OBJECTIVES)

Personal Employment Goal Statement (Support Plan Outcome)

|  |  |  |
| --- | --- | --- |
| **Employment Objective** | **Training Needed**  **to Meet Objective** | **Projected Date for Completion of Employment Objective** |
| 1. |  | Click here to enter a date. |
| 2. |  | Click here to enter a date. |
| 3. |  | Click here to enter a date. |
| 4. |  | Click here to enter a date. |

EMPLOYMENT STABILITY AND FADING PLAN

|  |  |  |  |
| --- | --- | --- | --- |
| **Long-term Goals** | **Strategy Applied** | **Objective Met?** | **If no, what measures are being taken?** |
| **Goal 1**: 0-1 year |  | Yes  No |  |
| **Goal 2**: 1-2 years |  | Yes  No |  |
| **Goal 3:**  2-3 years |  | Yes  No |  |

Important Dates

|  |
| --- |
| Support Plan Meeting Date: Click here to enter a date. |
| Effective Support Plan Date: Click here to enter a date. |
| ESP Effective Date *(Must be within 30 days of effective date of support plan)*: Click here to enter a date. |
| VR Approval Date: Click here to enter a date. |
| VR Denial Date: Click here to enter a date. |
| Reason for Denial *(if known)*: |
| Denial Reason: Unknown |
| Date Copy of ESP Provided to Person or Legal Rep over Governmental Services or Medical Decisions:  Click here to enter a date. |
| ESP Delivery Method to Person or Legal Rep over Governmental Services or Medical Decisions: Choose an item. |
| Date Copy of ESP Provided to Employee’s Support Coordinator (SC): Click here to enter a date. |
| ESP Delivery Method to Support Coordinator: Choose an item. |

Supported Employee’s Career Advancement

*Provider must furnish information and supports for the job seeker to make an informed choice regarding the type of work preferred, job changes, or career advancement opportunities available. Include all long-term goals. (See “Developmental Disabilities Medicaid Waiver Services Coverage and Limitations Handbook.”)*

|  |
| --- |
| Employee’s Performance Review Details: |
| Detail Manner of Assuring Employee of Informed Choice: |

EMPLOYMENT INFORMATION

Primary Job

|  |  |
| --- | --- |
| Current Business/Employer’s Name: | |
| Business Address: | City: |
| State: | Zip Code: |
| On-site Contact’s Name: | On-site Contact’s Position: |
| On-site Contact’s Telephone: | On-site Contact’s Email: |
| Date Hired in Current Position: Click here to enter a date. | Employee’s Position: |
| Salary or Hourly Wage: $ | Hours Worked Weekly: |
| Date of Last Promotion: Click here to enter a date. |  |
| Does employee work a minimum of 20 hours weekly, as required? Yes  No | |
| If *No*, provide justification to continue billing: | |
| Select All Benefits Received by Supported Employee:  Vacation Pay  Sick Leave  Retirement  Health Insurance  Other  If *Other* is selected, please describe: | |

Job Loss

If the primary job was lost, specify the reason: Choose an item.

If *Other* is selected, please describe:

Previous Work Record

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous Employers** | **Date Employed**  *(MM/DD/YYYY)* | **Position** | **Hours Worked**  **Weekly** |
| 1. | Click here to enter a date. |  |  |
| 2. | Click here to enter a date. |  |  |
| 3. | Click here to enter a date. |  |  |
| 4. | Click here to enter a date. |  |  |
| 5. | Click here to enter a date. |  |  |
| 6. | Click here to enter a date. |  |  |
| 7. | Click here to enter a date. |  |  |
| 8. | Click here to enter a date. |  |  |

Employment Accommodations

*Please check all that apply.*

|  |  |  |  |
| --- | --- | --- | --- |
| Customized Position |  | Personal Care Assistance |  |
| Equipment Modification |  | Subsidy |  |
| Flexible Work Schedule |  | Supported Living |  |
| Modified Production Quota |  | Transportation |  |
| Other |  |  | |

TRANSPORTATION

|  |
| --- |
| Transportation Provider Name: |
| Transportation Contact Telephone: |
| Transportation Paid By: |

NATURAL SUPPORTS

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Natural Supports** | **Name of Supporting Person**  *(First and Last)* | **Relationship** | **Telephone** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Plans to Increase Natural Supports

*Please describe the plans to increase natural supports.*

SUPPORTED EMPLOYMENT PROVIDER INFORMATION

General Information

|  |  |
| --- | --- |
| Provider Name: | Provider Address: |
| City: | State: |
| Zip Code: | |
| Medicaid Waiver Provider Number: | ABC Vendor ID Number: |
| Services Provided: Choose an item. | |
| Are you also a VR provider? Choose an item. |  |
| Current SE Professional Name: | Back-up Coach Name: |
| SE Professional Email: | Back-up Coach Email: |
| SE Professional Telephone: | Back-up Coach Telephone: |
| Number of Years of APD SE Coach Experience: | |
| Is the SE Professional a subcontractor? Choose an item. | |

Supported Employment Professional’s Pre-service Training Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Best Practices in Supported Employment** | | **Introduction to Social Security Work Incentives** | |
| Date Successful Completion: | | Date Successful Completion: | |
| Training Site: | | Training Site: | |
| City: | State: | City: | State: |
| Certified Trainer’s Name: | | Certified Trainer’s Name: | |

SUPPORTED EMPLOYMENT SERVICES

Phase 1 – Job Development (If APD-funded)

*(If not APD-funded and information can be obtained, please complete. If not, leave blank.)*

Date SE Services Began: Click here to enter a date.

Total Number of Months in Job Development:

Dates of Job Development: Begin Date:       End Date:

Model of SE Services: Choose an item.

Did job seeker receive more than 3 months of Phase 1 (Job Development services)? Choose an item.

*If more than 3 months of Job Development services were provided, justification is required.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **# SE Units Provided**  *(Proof of fading progression)* | **Amount Billed**  *(for SE Services)* | **Justification**  *(If in Job Development more than 3 months)* |
| Month 1 |  | $ |  |
| Month 2 |  | $ |  |
| Month 3 |  | $ |  |
| Month 4 |  | $ |  |
| Month 5 |  | $ |  |
| Month 6 |  | $ |  |

Phase 2 – Follow-Along (If APD-funded)

*(If not APD-funded and information can be obtained, please complete. If not, leave blank.)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **# SE Units Provided**  *(Proof of fading progression)* | **Amount Billed**  *(for Follow-Along)* | **Justification** |
| Month 1 |  | $ |  |
| Month 2 |  | $ |  |
| Month 3 |  | $ |  |

Did employee receive more than 3 years of Follow-along for the same job? Choose an item.

*If more than 3 years of Follow-along services were provided for one job for the employee, justification is required.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **# SE Units Provided**  *(Monthly Average)* | **Amount Billed**  *(Monthly Average*  *for Follow-along)* | **Justification**  *(If in Follow-along more than 3 years in same job)* |
| Year 2 |  | $ |  |
| Year 3 |  | $ |  |

SE Funding Source: Choose an item.

Specify (if *Other*):

AGENCY SUPPORTS

Employment Supports during Phase 1 Received from: Choose an item.

If *Other* was selected, please list the source:

Employment Supports during Phase 2 Received from: Choose an item.

If *Other* was selected, please list the source:

Waiver Support Coordinator (WSC)

|  |  |
| --- | --- |
| Support Coordination Agency Name: | |
| Agency Telephone: | Agency Fax Number: |
| WSC First Name: | WSC Last Name: |
| WSC Telephone: | WSC Email: |

Vocational Rehabilitation (VR)

|  |  |
| --- | --- |
| VR Counselor First Name: | Last Name: |
| VR Counselor Telephone: | VR Counselor’s Email: |

Agency for Persons with Disabilities (APD)

|  |  |
| --- | --- |
| Employment Liaison First Name: | EL Last Name: |
| EL Telephone: | EL Email: |

SOCIAL SECURITY ADMINISTRATION INFORMATION

Representative Payee Information

Does the supported employee have a representative payee (person legally responsible for reporting wages)?

Choose an item.

|  |
| --- |
| Representative Payee Name: |
| Representative Payee Telephone: |

Social Security Administration (SSA) Benefits Information

|  |  |
| --- | --- |
| Supplemental Security Income (SSI): Choose an item. | |
| SSI Contact Name: | SSI Contact Telephone: |
| Reporting Method: Choose an item. | |
| Social Security Disability Insurance (SSDI): Choose an item. | |
| SSDI Contact Name: | SSDI Contact Telephone: |
| Reporting Method: Choose an item. | |

SSA Work Incentives

Have SSA work incentives been applied? Choose an item.

*Select all SSA Work Incentives that have been utilized/applied.*

|  |  |  |  |
| --- | --- | --- | --- |
| Blind Work Expense |  | Special Conditions |  |
| Extended Period of Eligibility |  | Subsidy |  |
| IRWE |  | Trial Work Period |  |
| PASS |  | Unsuccessful Work Attempt |  |
| PESS |  | Unknown |  |
| SEIE |  | Other |  |

DATA COLLECTION AND MONITORING

There are three methods of data collection and monitoring:

1. **Service Logs**: Written documentation of the deliverables, time spent supporting the job seeker, and a summary of the strategic plans used for goal implementation and quantifying outcomes.
2. **Quarterly Summaries**: Approximately three months of service logs and quantified outcomes to illustrate the progression and challenges of services rendered.
3. **Annual Summaries**: A written report of the third quarterly summary which includes data on the current and previous outcomes of the individual’s progress toward his or her support plan goals for the year.

Supported Employee’s Career Advancement – Quarterly Review

*Documented quarterly review by the provider is required to furnish information and supports for the recipient to make an informed choice in the type of work preferred, job changes, or career advancement opportunities available. Include all long-term goals.*

Detail Employee’s Performance Review:

Detail Manner of Assuring Employee of Informed Choice:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Changes** | | | | **Professional’s Initials** |
| Click here to enter a date. | Yes |  | No |  |  |
| Click here to enter a date. | Yes |  | No |  |  |
| Click here to enter a date. | Yes |  | No |  |  |
| Click here to enter a date. | Yes |  | No |  |  |

SECOND JOB SECTION

*Please complete the section below for supported employees who have a second job.*

Supported Employment

Model of SE Service: Choose an item.

Employment Supports Received for This Job: Choose an item.

If *Other* is selected, please provide details:

Employment Information

|  |  |
| --- | --- |
| Current Business/Employer’s Name: | |
| Business Address: | City: |
| State: | Zip Code: |
| On-site Contact’s Name: | On-site Contact’s Position: |
| On-site Contact’s Telephone: | On-site Contact’s Email: |

|  |  |
| --- | --- |
| Date Hired *(If this is first job with SE services):*  Click here to enter a date. | Employee’s First Position: |
| Hourly Wage: $ | Hours Worked Weekly: |
| Date of Last Promotion: Click here to enter a date. | Type of Last Promotion: Choose an item. |
| Current Position: | If same job as above, select *N/A*: Choose an item. |
| Hourly Wage in Current Position: $ | |
| Hours Worked Weekly in Current Position: | |
| Does employee work a minimum of 20 hours weekly, as required? Choose an item. | |
| If *No*, provide justification to continue billing: | |
| Select All Benefits Received by Supported Employee:  Vacation Pay  Sick Leave  Retirement  Health Insurance  Other  If *Other* is selected, please describe: | |

SIGNATURES

*All involved parties of Supported Employment services shall comply with the requirements found in the Medicaid Waiver Services Coverage and Limitations Handbook. The signatures below affirm that the supported employee is aware of his or her rights and is providing informed consent to participate in the Supported Employment Program as described above.*

|  |  |
| --- | --- |
| Supported Employee’s Signature: | Date: Click here to enter a date. |
| Employment Specialist’s Signature: | Date: Click here to enter a date. |
| Employment Services Supervisor’s Signature *(if applicable):* | Date: Click here to enter a date. |