

EMPLOYMENT STABILITY PLAN

Date:

# CLIENT INFORMATION

## General Information

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Date of Birth: | iConnect ID: |
| Street: | City: |
| State: | Zip Code: |
| Telephone: | Email: |
| Emergency Contact Name: | Emergency Contact Telephone: |
| Highest Level of Education: Choose an item. | |
| Date Education Completed: | Check here if date is unknown: |

## Legal Representative for APD Services

|  |  |
| --- | --- |
| Is the client their own legal representative? Choose an item. | |
| Legal Rep First Name: | Legal Rep Last Name: |
| Street: | City: |
| State: | Zip Code: |
| Telephone: | Email: |

# SUPPORTED EMPLOYMENT PROVIDER INFORMATION

## General Information

|  |  |
| --- | --- |
| Provider Name: | Provider Address: |
| City: | State: |
| Zip Code: | |
| Services Provided: Choose an item. | |
| Are you also a VR provider? Choose an item. |  |
| Supported Employment Coach (SEC) Name: | Back-up Coach Name: |
| SEC Email: | Back-up Coach Email: |
| SEC Telephone: | Back-up Coach Telephone: |
| Is the SEC a subcontractor? Choose an item. | |

# 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: | Client’s Position: |
| Hourly Wage: $ | Hours Worked Weekly: |
| Has the client received a promotion on this job? Choose an item. Date of Last Promotion:  Type of Promotion received *(check all that apply)*: Performance-based  Monetary/Raise  New Position  If new position received, what was the title of the previous position? | |
| Select All Benefits Received by the client:  Vacation Pay  Sick Leave  Retirement  Health Insurance  Other  If *Other* is selected, please describe: | |
| Employment Supports Received for This Job: Choose an item.  If *Other* is selected, please describe: | |

## Second Job

*Please complete the section below for clients who have a second job OR select N/A*

|  |  |
| --- | --- |
| 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: | Client’s Position: |
| Hourly Wage: $ | Hours Worked Weekly: |
| Has the client received a promotion on this job? Choose an item. Date of Last Promotion:  Type of Promotion received *(check all that apply)*: Performance-based  Monetary/Raise  New Position  If new position received, what was the title of the previous position? | |
| Select All Benefits Received by the client:  Vacation Pay  Sick Leave  Retirement  Health Insurance  Other  If *Other* is selected, please describe: | |
| Employment Supports Received for This Job: Choose an item.  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** | **Dates of Employment**  *(Begin/End Dates)* | **Position** | **Hours Worked**  **Weekly** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |

# IMPLEMENTATION PLAN

|  |  |  |
| --- | --- | --- |
| **What I Want to Accomplish this Year** Employment Goal(s) | | |
|  | | |
| **Short-Term Objectives to Reach Goal(s)** | **Level of Support & Training Needed to Meet Each Objective** | **Projected Date of Completion** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| **Method(s) Used for Data Collection** | | |
|  | | |
| **Follow-up** *Complete at the end of service year* | | |
| Have the employment goal(s) and objectives been met? Yes  No | | |
| If no, what measures are being taken? | | |

# NATURAL SUPPORTS

|  |  |  |  |
| --- | --- | --- | --- |
| **Plan to Increase Natural Supports in the Workplace** | | | |
|  | | | |
| **Type of Natural Supports** | **Name of Supporting Person**  *(First and Last)* | **Relationship** | **Telephone** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Follow-up** *Document attempts made to increase natural supports throughout the service year (update as needed).* | | | |
|  | | | |

# SUPPORTED EMPLOYMENT SERVICES FADING PLAN

Model of SE Services: Choose an item. Date SE Services Began:

|  |  |
| --- | --- |
| **Plan for Fading SE Services** | **Projected Service Period** *(Begin/End Dates)* |
|  |  |

## Phase 1 Job Development – Proof of Fading Progression (If APD-funded)

|  |
| --- |
| Employment Supports during Phase 1 Received from: Choose an item.  If *Other* was selected, please list the source: |
| Dates of Job Development: Begin Date:       End Date:       Total # of Months in Job Development: |

*Complete the table below if phase 1 job development was APD-funded. If not, leave blank and select N/A*

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

## Phase 2 Follow-Along – Proof of Fading Progression

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Service Yr** | **MM/YY** | **# SE Units Provided**  *(Proof of fading progression)* | **Amount Billed**  *(for Follow-Along)* | **Justification** |
| Month 1 |  |  | $ |  |
| Month 2 |  |  | $ |  |
| Month 3 |  |  | $ |  |
| Month 4 |  |  | $ |  |
| Month 5 |  |  | $ |  |
| Month 6 |  |  | $ |  |
| Month 7 |  |  | $ |  |
| Month 8 |  |  | $ |  |
| Month 9 |  |  | $ |  |
| Month 10 |  |  | $ |  |
| Month 11 |  |  | $ |  |
| Month 12 |  |  | $ |  |

*(Complete the table below if the client has received more than a year of service for the same job. If this is the first year of service, leave blank.)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year of SE Service** | **Date Range**  (MM/YY-MM/YY) | **# SE Units Provided**  *(Monthly Average)* | **Amount Billed**  *(Monthly Average*  *for Follow-along)* | **Justification**  *(If more than 3 years of Follow-along services were provided for one job, justification is required)* |
| Year 1 |  |  | $ |  |
| Year 2 |  |  | $ |  |
| Year 3 |  |  | $ |  |
| Year 4 |  |  | $ |  |
| Year 5 |  |  | $ |  |
| Year 6 |  |  | $ |  |
| Year 7 |  |  | $ |  |

# EMPLOYMENT ACCOMMODATIONS

*Please check all that apply.*

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

If *Other* is selected, please describe:

# TRANSPORTATION

|  |  |
| --- | --- |
| Transportation Provider Name: | Transportation Contact Telephone: |
| Transportation Paid By: Choose an item. |  |

# EMPLOYEE PERFORMANCE & CAREER ADVANCEMENT

## Client’s Periodic Performance Review

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Performance Review Notes** | **Date of Review** | **Satisfactory?** | | | | **SEC’s Initials** |
|  |  | Yes |  | No |  |  |
|  |  | Yes |  | No |  |  |
|  |  | Yes |  | No |  |  |
|  |  | Yes |  | No |  |  |

## Career Interests & Future Planning

Long-Term Career Goal(s):

Type of work preferred by client:

Method for assuring that client is informed of choice:

# SOCIAL SECURITY ADMINISTRATION INFORMATION

## Representative Payee Information

Does the client 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. | |
| Have Social Security benefits ended due to employment? Choose an item. If so, when? Enter a date  Is the client receiving continued Medicaid eligibility covered under the 2019 Working People with Disability Legislation? Choose an item. | |

## SSA Work Incentives

*Select all applicable SSA Work Incentives:*

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

If *Other* is selected, please describe:

Complete the table below for all applicable work incentives.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Applicable Work Incentives** | **Utilized?** | | | | **Reason for use or justification for non-use** |
|  | Yes |  | No |  |  |
|  | Yes |  | No |  |  |
|  | Yes |  | No |  |  |
|  | Yes |  | No |  |  |
|  | Yes |  | No |  |  |
|  | Yes |  | No |  |  |

## Notes on Reporting of Wages and Work Incentives

Who is responsible for reporting wages and work incentives on a monthly and quarterly basis?

Notes:

# AGENCY SUPPORTS

## 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: |

## Important Dates

|  |
| --- |
| Support Plan meeting date: |
| Support Plan effective date: |
| ESP effective date *(Must be within 30 days of effective date of support plan)*: |
| Date copy of ESP provided to client’s Support Coordinator (SC): |
| ESP delivery method to Support Coordinator: Choose an item. |
| Date copy of ESP provided to client or legal representative: |
| ESP delivery method to client or legal representative: Choose an item. |
| VR approval date: |
| VR denial date: |
| Reason for VR denial *(if known)*:  Denial reason: unknown |

# 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 client is aware of his or her rights and is providing informed consent to participate in the Supported Employment Program as described above.*

|  |  |
| --- | --- |
| Client’s Signature: | Date: |
| Employment Specialist’s (SEC’s) Signature: | Date: |
| Employment Services Supervisor’s Signature *(if applicable):* | Date: |