

EMPLOYMENT STABILITY PLAN

Date: ***ESP EFFECTIVE DATE***

SUPPORTED EMPLOYEE INFORMATION

General Information

|  |  |
| --- | --- |
| First Name: ***Brian***  | Last Name: ***Rothey*** |
| Date of Birth:***09/19/1983*** | PIN: ***091983*** |
| Social Security Number: ***123456789*** | Medicaid Number: ***987654321*** |
| Street: ***1313N Tampa Street*** | City: ***Tampa*** |
| State: ***FL***   | Zip Code: ***33602*** |
| Telephone: ***813-233-4340*** | Email:  |
| Emergency Contact Name: ***Johnny Bith*** | Emergency Contact Telephone: ***813-321-6549*** |
| Highest Level of Education: ***College Diploma*** |
| Date Education Completed:  | Date Education Completed: Unknown: [x]  |

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.*

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| --- |
| Is Employee their own Legal Representative? ***Yes*** |
| Legal Rep First Name: ***Jeremy*** | Legal Rep Last Name: ***Gunn*** |
| Street: ***1234 Main St.*** | City: ***Tampa*** |
| State: ***FL*** | Zip Code: ***33602*** |
| Telephone: ***813-123-4456*** | Email: ***jermgunn@gmail.com*** |

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. ***In this section, you are going to copy, verbatim, the Support Plan Goals that are related to Supported Employment Coaching.***
2. ***This individual’s goal is: “Jaime would like to work”.  This is the only goal listed in his/her support plan.***
 | 1. ***This section is going to include your detailed “action-plan”, the “meat and potatoes” of how you plan to implement, address and achieve this individual’s goal.***
2. ***Where, who, what, why, when, and how.  What type of work is the individual interested in? Where would he/she like to work? Who is going to assist in developing and applying for jobs and what are their responsibilities?  How do you plan on assisting the individual with the application, interview, and training process?  Discuss and agree upon when you would like to meet and provide services, etc.***
 | ***7/19/2017*** |
| 1. ***If there is more than one goal in the Support Plan that is related to Supported Employment, list here.***
 |       | 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 ***This section is asking what the Supported Employees long term goals are.  You will need to address these with the individual.  I.E.: What would you like to see accomplished within our initial Support Plan year?  It can be the same as the Support Plan Goal (Jaime would like to work, or Jaime would like to find a job working with animals)*** | ***Identify what strategies you as an Employment Coach implemented in an effort to accomplish this goal(s).******Same for 1-2 years, and 2-3 years.  Be sure to include a natural progression towards fading.  In a perfect situation, the individual will secure employment within the first year.  Goal 1 accomplished.  During the second year, the individual’s goal may be to increase hours.  During the third year, the individual’s goal may be to become more independent at work, increasing natural supports (coworkers, etc.) and decreasing paid supports (job coach).*** | Yes [ ] No [ ]  |       |
| **Goal 2**: 1-2 years       |       | Yes [ ] No [ ]  |       |
| **Goal 3:**  2-3 years       |       | Yes [ ] No [ ]  |       |

Important Dates

|  |
| --- |
| Support Plan Meeting Date: ***This typically occurs during the 3rd Quarter / Annual Meeting*** |
| Effective Support Plan Date: ***This is found on the Support Plan listed as: Effective Date***  |
| ESP Effective Date: ***Within 30-days of receipt of Support Plan*** |
| VR Approval Date: ***If known. If unknown, ask WSC or contact local VR Offices. A-2 WSC responsibility*** |
| VR Denial Date: ***If known. If unknown, ask WSC or contact local VR Offices*** |
| Reason for Denial *(if known)*: ***If known. If unknown, ask WSC or contact local VR Offices***  |
| Denial Reason: Unknown [ ]  |
| Date Copy of ESP Provided to Person or Legal Rep over Governmental Services or Medical Decisions:***MUST be provided to individual and WSC within 30-days of receipt of Support Plan***  |
| ESP Delivery Method to Person or Legal Rep over Governmental Services or Medical Decisions: In Person |
| Date Copy of ESP Provided to Employee’s Support Coordinator (SC): ***MUST be provided to individual and WSC within 30-days of receipt of Support Plan*** |
| ESP Delivery Method to Support Coordinator: In Person |

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: ***Document any and all reviews that employer has given (quarterly, bi-annually, annually).  Raise awarded? Disciplinary Action?*** |
| Detail Manner of Assuring Employee of Informed Choice: ***Conversation and documentation with Supported Employee regarding his/her knowledge and understanding of his/her choice as to type of work, job changes, or career advancement opportunities.*** |

EMPLOYMENT INFORMATION

Primary Job

|  |
| --- |
| Current Business/Employer’s Name: ***Adult Care Housing, Inc.***  |
| Business Address: ***7800 92nd Ave N*** | City: ***Tampa*** |
| State: ***FL***  | Zip Code: ***33602*** |
| On-site Contact’s Name: ***Anne Hendon***  | On-site Contact’s Position: QA Coordinator |
| On-site Contact’s Telephone: ***813-456-3211*** | On-site Contact’s Email: ***Bjordan@yahoo.com*** |
| Date Hired in Current Position: 10/17/2015 | Employee’s Position: ***Receptionist II*** |
| Salary or Hourly Wage: ***$ 8.56*** | Hours Worked Weekly: ***15*** |
| Date of Last Promotion: ***The last time Minimum wage was increased*** |  |
| Does employee work a minimum of 20 hours weekly, as required? Yes [ ]  No [x]  |
| If *No*, provide justification to continue billing: ***In this section, you can describe what barriers or issues are occurring to prevent the individual from working more than 20-hours a week. Covid-19 limited opportunities for onsite work.*** |
| Select All Benefits Received by Supported Employee:Vacation Pay [ ]  Sick Leave [ ]  Retirement [ ]  Health Insurance [ ]  Other [x]  If *Other* is selected, please describe: ***Vision*** |

Job Loss

If the primary job was lost, specify the reason: ***Termination \*\*drop down selection\*\****

If *Other* is selected, please describe:

Previous Work Record

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous Employers** | **Date Employed***(MM/DD/YYYY)* | **Position** | **Hours Worked****Weekly** |
| 1. ***Has the individual held previous employment?*** | ***And WHEN?? \*\*drop down selection\*\**** | ***What was the individual’s title/duties?*** | ***How many hours did the individual work per week (average)?*** |
| 2. ***If so, WHERE?*** | 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  |[x]  Personal Care Assistance |[ ]
| Equipment Modification |[x]  Subsidy |[ ]
| Flexible Work Schedule |[x]  Supported Living |[x]
| Modified Production Quota |[ ]  Transportation |[x]
| Other |[ ]   |

TRANSPORTATION

|  |
| --- |
| Transportation Provider Name: ***How does this person get to and from work? City Bus, Cab Service, bicycle, etc.*** |
| Transportation Contact Telephone:       |
| Transportation Paid By:       |

NATURAL SUPPORTS

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Natural Supports** | **Name of Supporting Person***(First and Last)* | **Relationship** | **Telephone** |
| ***coworker*** | ***Unpaid support*** |       | ***(XXX)XXX-XXXX*** |
| ***neighbor*** | ***Unpaid support*** |       | ***(XXX)XXX-XXXX*** |
| ***family member*** | ***Unpaid support*** |       | ***(XXX)XXX-XXXX*** |
|       |       |       |       |

Plans to Increase Natural Supports

*Please describe the plans to increase natural supports.*

***How do you plan on facilitating the increase of natural supports***?

SUPPORTED EMPLOYMENT PROVIDER INFORMATION

General Information

|  |  |
| --- | --- |
| Provider Name: ***AGENCY NAME***  | Provider Address: ***1234 Easy Street*** |
| City: ***St. Petersburg*** | State: ***FL*** |
| Zip Code: ***33703*** |
| Medicaid Waiver Provider Number: ***0123987*** | ABC Vendor ID Number: ***5463728*** |
| Services Provided: ***Follow-along*** ***\*\*drop down selection\*\**** |
| Are you also a VR provider? Yes ***\*\*drop down selection\*\**** |  |
| Current SE Professional Name: Gary Hartfield | Back-up Coach Name: ***Val Gaddard*** |
| SE Professional Email: ***Garyhartfield@internet.com*** | Back-up Coach Email: ***Val@email.com*** |
| SE Professional Telephone: ***(727)338-5555*** | Back-up Coach Telephone: ***(813)753-9512*** |
| Number of Years of APD SE Coach Experience: ***32*** |
| Is the SE Professional a subcontractor? No ***\*\*drop down selection\*\**** |

Supported Employment Professional’s Pre-service Training Information

|  |  |
| --- | --- |
| **Best Practices in Supported Employment** | **Introduction to Social Security Work Incentives**  |
| Date Successful Completion: ***7/21/2016*** | Date Successful Completion: ***7/21/2016*** |
| Training Site: ***APD*** | Training Site: ***APD***  |
| City: ***Tampa*** | State: ***FL*** | City: ***Tampa*** | State: ***FL*** |
| Certified Trainer’s Name: ***Tina Johnson*** | Certified Trainer’s Name: ***Tina Johnson*** |
|  |  |

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: ***Has individual gone through VR Services? Did VR deny the individual for SE services? When did APD services begin?***

Total Number of Months in Job Development: ***How long has individual been in Job Development?***

Dates of Job Development: Begin Date:       End Date:

Model of SE Services: Job Development ***\*\*drop down selection\*\****

Did job seeker receive more than 3 months of Phase 1 (Job Development services)? Yes

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

***Why has the individual been in Job Development for more than 3-months? What barriers/obstacles has the Employment Specialist encountered?***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **# SE Units Provided** *(Proof of fading progression)* | **Amount Billed** *(for SE Services)* | **Justification***(If in Job Development more than 3 months)* |
| Month 1 | ***24 QH*** | $***214.32*** |       |
| Month 2 | ***20 QH*** | $***178.60*** |       |
| Month 3 | ***16 QH*** | $***142.88*** |       |
| Month 4 | ***16 QH*** | $***142.88*** |       |
| Month 5 | ***16 QH*** | $***142.88*** |       |
| Month 6 | ***12 QH*** | $***107.16*** |       |

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 | ***12*** | $***107.16*** |       |
| Month 2 | ***12*** | $***107.16*** |       |
| Month 3 | ***8*** | $***71.44*** |       |

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 | ***8*** | $***71.44*** |       |
| Year 3 | ***4*** | $***35.72*** |       |

SE Funding Source: ***APD*** ***\*\*drop down selection\*\****

Specify (if *Other*): ***Could be funded through an Agency Grant, scholarship, etc.***

AGENCY SUPPORTS

Employment Supports during Phase 1 Received from: Agency for Persons with Disabilities

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

Employment Supports during Phase 2 Received from: ***Agency for Persons with Disabilities \*\*drop down selection\*\****

If *Other* was selected, please list the source: ***Could be funded through an Agency Grant, scholarship, etc.***

Waiver Support Coordinator (WSC)

|  |
| --- |
| Support Coordination Agency Name: ***ABC WSC*** |
| Agency Telephone: ***(727) 331-5522*** | Agency Fax Number:       |
| WSC First Name: ***Jane***  | WSC Last Name: Doe |
| WSC Telephone: ***(727) 556-9998*** | WSC Email**: J**.***Doe@email.com*** |

Vocational Rehabilitation (VR)

|  |  |
| --- | --- |
| VR Counselor First Name: ***Edith*** | Last Name: ***Fredding*** |
| VR Counselor Telephone: ***(813)233-3333*** | VR Counselor’s Email: ***Edith@internet.org*** |

Agency for Persons with Disabilities (APD)

|  |  |
| --- | --- |
| Employment Liaison First Name: ***Jerry*** | EL Last Name: ***Garcia*** |
| EL Telephone: ***(813)444-1234*** | EL Email: ***Wavygravy@icecream.com*** |

SOCIAL SECURITY ADMINISTRATION INFORMATION

Representative Payee Information

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

 Yes

|  |
| --- |
| Representative Payee Name: ***Sunshine Finacial*** |
| Representative Payee Telephone: ***(813)456-9999*** |

Social Security Administration (SSA) Benefits Information

|  |
| --- |
| Supplemental Security Income (SSI): Yes |
| SSI Contact Name: SELF | SSI Contact Telephone: SELF |
| Reporting Method: *Fax with Confirmed Transmission* ***\*\*drop down selection\*\**** |
| Social Security Disability Insurance (SSDI): No |
| SSDI Contact Name: ***N/A*** | SSDI Contact Telephone: ***N/A*** |
| Reporting Method: Choose an item.  |

SSA Work Incentives

Have SSA work incentives been applied? Yes

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

|  |  |
| --- | --- |
| Blind Work Expense |[ ]  Special Conditions |[ ]
| Extended Period of Eligibility |[ ]  Subsidy |[x]
| IRWE |[x]  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: ***When was the last, or upcoming, performance review?***

Detail Manner of Assuring Employee of Informed Choice: ***How are you ensuring that the Supported Employee is aware of the opportunities for advancement, job changes, schedule changes, or stability?***

|  |  |  |
| --- | --- | --- |
| **Date**  | **Changes** | **Professional’s Initials** |
| ***1st Quarterly Date*** | Yes  |[ ]  No |[ ]      |
| ***2nd Quarterly Date*** | Yes  |[ ]  No |[ ]      |
| ***3rd Quarterly/Annual Date*** | Yes  |[ ]  No |[ ]      |
| ***4th Quarterly 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. |