# **Supported Employment Long-Term Support Plan**

# *(If this person will receive Long Term Support services funded by a Medicaid waiver this plan needs to be developed jointly by the employment specialist and the individual’s team*)

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| **SE Provider** |  | **Name of Consumer** |  |
| **Employer** |  | **Job Title or Function** |  |
| **Wage per Hour** |  | **Hours per Week** |  |

### Frequency and Description of On-Site Services / Supports provided by the employment specialist)

*What, if anything, do you do with and/or for the employee regarding job tasks? How do you plan to shift these tasks to employee and/or natural supports?   
How often, and in what way, will you follow up with employee and employer?*

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### Frequency and Description of Off-Site Services and Supports (provided by Employment specialist and other service providers)

*Name, role, type of service, frequency needed. For example: transportation, assistance at home, therapies, Employment Specialist following up about job off site/email/phone.*

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### Description of Natural Supports on the Job

*Be specific – name, title/role, type of support, description, and frequency needed.*

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### Other Important Information

*Anything else that may be needed to support employee, for example: safety concerns, criminal history expungement, special medication considerations, etc.*

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**Consumer’s Future Employment Goals**

*These should be person centered and will change over time. Examples include: developing relationships at work, increasing efficiency, taking on new tasks, increasing hours, career advancement, etc.*

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### How was input obtained for this plan? *Name & role of those involved – employee, employment specialists, guardian, other support people, team members, etc.*

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| **Participant**  **Signature:** |  | Date: |  |
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| **Employment Specialist Signature:** |  | Date: |  |

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| **Case Manager Signature** (acknowledges inclusion as part of Plan of Care): |  | Date: |  |