

## EMPLOYMENT SUPPORT AIDE AGREEMENT

Member's Name *(Last, First, M.I.)* \_\_\_\_\_ Date \_\_\_\_\_

Support Coordinator's Name \_\_\_\_\_ DDD I.D. No. \_\_\_\_\_

Qualified Vendor's Name \_\_\_\_\_ Phone Number *(Including area code)* \_\_\_\_\_

Qualified Vendor's Address *(No., Street)* \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

The purpose of this agreement is to delineate the services and supports to be provided including time frames. **The document should be updated and amended, as necessary.**

PERSONAL CARE	YES/NO	DAILY HOURS *(UP TO 1 HOUR PER DAY)	WEEKLY HOURS
Assisting with lavatory usage	Yes No		
Assisting at meal times and breaks	Yes No		
Assisting with self-medication or medication reminders	Yes No		
Assisting with ambulation	Yes No		
Other	Yes No		
BEHAVIORAL INTERVENTION	YES/NO	DAILY HOURS *(UP TO 3 HOURS PER DAY)	WEEKLY HOURS
Provide behavioral intervention as needed by assisting in resolving behaviors inappropriate for the workplace.	Yes No		
Assist the consumer in resolving any life/personal concerns that may interfere with the job performance.	Yes No		
Communicate with all appropriate persons when the member presents any additional medical or social needs during the course of the service delivery in order to refer for or obtain additional needed supports.	Yes No		
Other	Yes No		
JOB RELATED SUPPORTS		YES/NO	WEEKLY HOURS
Supports and services including:		Yes No	

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ Total Hours-Weekly \_\_\_\_\_ Total Hours-Monthly \_\_\_\_\_

Member's Name \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Support Coordinator's Name \_\_\_\_\_

Support Coordinator's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Name \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Qualified Vendor's Name \_\_\_\_\_

Qualified Vendor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employment Program Specialist's Name \_\_\_\_\_

Employment Program Specialist's Signature \_\_\_\_\_ Date \_\_\_\_\_

DPM/Designee's Name \_\_\_\_\_

DPM/Designee's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Routing: Original – Support Coordinator, Copy - Consumer/Consumer's Representative, Copy – Qualified Vendor