



## Foundational Community Supports: Supported Employment Assessment

Initial assessment

Reauthorization

\*Indicates a required field.

<b>*Date:</b>	<b>*Name:</b>	<b>*ProviderOne ID:</b>	<b>*Date of birth:</b>
<b>Address (not required if homeless):</b>		<b>*City, State ZIP:</b>	
<b>Phone number:</b>		<b>Email:</b>	
<b>Member of a federally recognized American Indian/Alaska Native tribe?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify which tribe:</i>		<b>Veteran:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<b>*Provider agency name:</b>	

### Part A: Complex needs eligibility requirements

*Information in this section is necessary in order to determine eligibility for supported employment services.*

#### \*Health need (must select at least one)

**The client meets one of the following criteria (as determined by a licensed behavioral health agency):**

- Enrolled in the state Housing and Essential Needs (HEN), or Aged, Blind or Disabled (ABD) Program. *(Please provide the reward letter.)*
- Diagnosed with a mental illness resulting in the need for improvement, stabilization, or prevention of deterioration of functioning resulting from the presence of a mental illness
- Diagnosed with a substance use disorder, as determined by meeting a one or higher level on the American Society of Addiction Medicine Criteria
- Needs assistance with three or more activities of daily living (ADL) or one or more hands-on ADL (as determined by a *Comprehensive Assessment and Resource Evaluation (CARE) Assessment*)

**\*Risk factors to be approved by a qualified licensed professional (must select at least one):**

*Document any conditions and diagnoses that contribute to one or more of the following risk factors.*

- At risk for deterioration of mental illness and/or substance use disorder, including one or more of the following:** *Persistent or chronic risk factors, such as social isolation due to a lack of family or social supports; poverty; criminal justice involvement; homelessness; care for mental illness and/or substance use disorder requiring multiple provider types, including behavioral health, primary care, long-term services and supports; or a past psychiatric history with no significant functional improvement that can be maintained without treatment and supports*
- Dysfunction in role performance:** *Frequently disruptive or struggling in work or school/training settings resulting in termination or suspension/expulsion; unable to work, attend school or meet other developmentally appropriate responsibilities; difficulty with daily living, communication, interpersonal skills, self-care, and self-direction*
- Substance use treatment:** *Has substance use disorder with two or more episodes of residential and/or inpatient treatment in the past two years*
- An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury (must be the result of a CARE Assessment)
- Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment (must be the result of a HEN/ABD Progressive Evaluation process)

Please provide any additional details (if applicable):

**Part B: Employment assessment**

Please fill out to the best of your ability. Information in this section assesses the individual's employment needs, preferences and capacities. This information is required but does not impact eligibility.

**Is the client interested in seeking employment?**  Yes  No If yes, what is the source of this answer:

- Client statement
- Referral from clinician/case manager/other
- Family discussion (or legal guardian or designated representative)  Other:

**\*Employment status:**

- Unemployed
- Employed part time
- Employed full time
- Nonpaid employment activities
- Enrolled in training/education program

**Income source (check all that apply):**

- Social Security (SSA)
- Pension
- Social Security Income (SSI)
- Social Security Disability Income (SSDI)
- Temporary Assistance for Needy Families (TANF)
- Aged, Blind and Disabled (ABD)
- Employment
- Other:

**\*Total income:**

- Less than \$10,000
- \$10,000 to \$14,999
- \$15,000 to \$19,999
- \$20,000 to \$24,999
- \$25,000 to \$29,999
- \$30,000 to \$34,999
- \$35,000 or more

**\*Housing type:**

- Transitional/temporary housing
- Permanent housing
- Not housed (homeless)

**\*If homeless, choose type:**

- Living in a place not meant for human habitation (for example, car)
- In an emergency shelter
- Homeless but admitted to a hospital or other institution for less than 30 days
- At imminent risk of losing housing
- Evicted or foreclosed within 30 days with no future residence identified
- Couch surfing or doubled up
- Other:

**Please identify what information indicates the individual would benefit from supported employment services (check all that apply):**

- Work history with gaps and poor job tenure
- Unclear vocational goals
- Poor prevocational skills (no resume, lacking interviewing skills, etc.)
- Client self-assessment of readiness for employment is low
- Major health issues have affected employment consistently in past or potentially may affect it in the future
- Client's stated request for ongoing support

**The above assessment information was obtained by (check all that apply):**

- Client direct statements
- Clinician/case manager/other assessment in referral to employment services
- Other:

**Client strengths in terms of employment (check all that apply):**

- Motivation
- Natural supports from family and friends
- Flexible in terms of job
- Has own transportation
- Educational attainment
- Previous good experience in job of choice
- Good references
- Has good job search skills
- Relates well interpersonally

**Client barriers that need to be addressed in terms of employment (check all that apply):**

**Note: These are areas for support, not disqualifiers or screen-out mechanisms for employment.**

- Little family and friend support
- Lacks own transportation
- Poor educational attainment
- Little prior work experience
- Poor prior work experience
- Ongoing substance abuse

**Notes:**

**Assessment completed by:**

**Position/credentials:**

**Date:**

**Signature:**

**\*Provider agency name:**

**Assessment supervised by (if applicable):**

**Position/credentials:**

**Date:**

**Signature:**

**\*Enrollee consent for services (print name):**

*\*Please indicate verbal consent in the notes below if signature was not attainable (required if no signature).*

**\*Enrollee signature:**

**\*Date:**

**Notes:**