**Exhibit G**

Grays Harbor County

# Individualized Plan (IP)

Developmental Disabilities Employment & Day Program

**SELECT:** Service Category - **Individual Supported Employment (IE)**

**SELECT:** Reason for Report - **Annual Plan**

| | | |
|---|---|---|
| **1. Client Legal Name:** | **Legal Guardian:** ☐ N/A | **2. DDA Case Manager Name:** |
| **3. Equal access provided due to limited ability to speak, read, or write English well enough to understand and communicate effectively. (Reference DDA Policy 5.05 Limited English Proficient):** ☐ N/A ☐ Yes services provided: | | |
| **4. Provider Agency Name and Staff Person's Phone Number:** | | **5. Client's ADSA ID number:** |
| **6. Individuals & their relationships to client involved in consultation of this plan and date of the consultation:** | | |

| Input from: | Date: | Input was in the way of: |
|---|---|---|
| ☐ Client | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |
| ☐ Friend/Relative | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |
| ☐ Family/Residential | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |
| ☐ Guardian | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |
| ☐ Employer | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |
| ☐ Case Manager | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |
| ☐ County Staff | | ☐ Face to Face Meeting ☐ E-mail ☐ Phone Call ☐ Formal Meeting |

**Consultation(s) were completed to develop additional strategies as a result of no paid employment within 6 months:**
☐ **N/A** ☐ **Yes** ☐ **No If no please explain:**

| | | |
|---|---|---|
| **7. Provider Staff Name:** | **8. Date of this Report:** | **9. Timeline of this Report:** |
| **10. Maximum Monthly Support Hours: Hours** | **11. Base Hours per Month: Hours** | **12. Decreased Hours** (based on the following): |

**13. Add-on Hours** (base on the following): ***Hours***
**Work shift:(Example:** Mondays 1.5 hours, Tuesdays 2 hour)

***Description of:***
a) ***Additional supports needed:***
b) ***Numerical breakdown of how support hours will be spent***
c) ***Fade plan to decrease hours of support***

**14. Short-term Supports** (based on the following): ***Hours (Maximum of 6 months at a time)***

***Description of:***
a) ***Additional supports needed***
b) ***Numerical breakdown of how support hours will be spent***
c) ***Fade plan to decrease hours of support***

**15. Client of DVR:** ☐ N/A at this time ☐ Yes ☐ No If No please explain:
**Date put in request to case manager :**_____

| | | | |
|---|---|---|---|
| **DVR Plan Included** | ☐ Vocational Evaluation | ☐ Intensive Training | ☐ Trial Work Experience |
| | ☐ Community-based Assessment | ☐ Job Retention | ☐ Job Placement |
| **Additional Comments:** | | | |

| **Alternative Funding Explored, Utilizing and Outcome(s):** | |
|---|---|
| Benefit Analysis | ☐ N/A ☐ Yes ☐ No |
| PASS PLAN | ☐ N/A ☐ Yes ☐ No |
| IRWE | ☐ N/A ☐ Yes ☐ No |

| | |
|---|---|
| Ticket to Work | ☐ N/A ☐ Yes ☐ No |
| 1619a or 1619b | ☐ N/A ☐ Yes ☐ No |
| Private Pay | ☐ N/A ☐ Yes ☐ No |

**16. Person Centered Plan?** ***(Every 12 months if not in paid employment)***
**Initial Plan Date:** **Updates:**

**17. Individuals who provided input on the current Person Centered Planning meeting** ***(Name and relationship to the person):***

**18. Positive Behavior Support Plan (PBSP)?** ☐ No ☐ Yes
**Initial Plan Date:** **Updates:**
***(If the most recent plan is over 12 months old ask the case manager about an updated plan)***

**19. Individual's strengths, skills, gifts, interest and preferred activities:**

**20. Preferred number of hours per week the individual wishes to work/be involved in the community:**

**21. Preferred job type/community activity the individual wishes to obtain or maintain:**

**22. Preferred work shift and wages the individual wishes to earn per month:**

**23. Identification and provision of supports necessary for job/community inclusion has been provided. Support may include, but not limited to:**
**Job Restructuring** ☐ No ☐ Yes ☐ N/A at this time
**Work Environment Modifications** ☐ No ☐ Yes ☐ N/A at this time
**Work Materials or Routine Adaptation** ☐ No ☐ Yes ☐ N/A at this time
**Identification of Job Counseling Needs** ☐ No ☐ Yes ☐ N/A at this time
**Identification of resources necessary for transportation** ☐ No ☐ Yes ☐ N/A at this time

| | | |
|---|---|---|
| **24. Volunteer Site:** | **25. Date began (Time limited):** | **26. Estimated end date:** |
| **27. Title:** | **28. Volunteer days per week:** | **29. Monthly volunteer hours:** |

**30. Purpose of the volunteer opportunity:** ☐ **Exploration** ☐ **Assessment** ☐ **Training** ☐ **Other:**_____

**31. Intended outcome of the volunteer opportunity:**

**32. Volunteering Continuing?:** ☐ Yes ☐ No **Same site?:** ☐ Yes ☐ No
**If the "Yes" describe why and how continuing volunteering will assist the individual with their employment goal:**

**33. Volunteer opportunity complies with U.S. Department of Labor standards** ☐ Yes ☐ No

**34. Is Individual Technical Assistance needed?** ☐ Yes ☐ No
**Indicate the type of Individual Technical Assistance is needed:**
☐ **Assistive Technology** ☐ **Autism Specialist** ☒ **Behavioral Consultation** ☐ **Benefits Analysis**
☐ **Communication Assistance** ☐ **Person Centered Planning** ☐ **Expert assistance with job development**
☐ **Other:** _____
**What will the final product be with this Individual Technical Assistance (a plan, benefits analysis report, etc.)?**
**Please describe:**

**35. State-adopted self-employment guidelines are followed:** ☐ N/A ☐ No ☐ Yes
**Business license: Business plan** ☒ No ☐ Yes **If no explain:**
**Business plan** ☐ No ☐ Yes **If no explain:**
**Established benchmarks for financial gain** ☐ No ☐ Yes **If no explain:**
**Progress towards providing a living wage** ☐ No ☐ Yes **If no explain:**
**State adopted self-employment guidelines being followed** ☐ No ☐ Yes **If no explain:**

| **36. Employer:** | **37. Job Title:** | **38. Date began:** |
|---|---|---|
| **39. Monthly Paid Hours of Employment & Work Shift:** | **40. Hourly wage:** | **41. Employment Benefits:** |

**42. Changes since last plan:**
**Job Duties:** ☐ Increased ☐ Decreased ☐ No change
**Hourly Wage:** ☐ Increased ☐ Decreased ☐ No change
**Hours of Paid Employment:** ☐ Increased ☐ Decreased ☐ No change

**43. Individual is satisfied with:**
**Place of Employment** ☐ No ☐ Yes ☐ N/A **Number of Work Hours** ☐ No ☐ Yes ☐ N/A **Wages** ☐ No ☐ Yes ☐ N/A

**44. Is the individual currently:**
**Working less than 20 hours a week?** ☐ Yes ☐ No ☐ N/A **If yes, hours worked per week?**
**If working less than 20 hours per week please include strategies for increasing hours:**

**Unemployed?** ☐ No ☐ Yes ☐ N/A **If yes, months unemployed:** _____
**Participating in activities, events and/or organizations in the community?** ☐ Yes ☐ No (List Activities)

| **45. Wages Reported to SSA by:** Name and relationship | **46. Annual Social Security Administration Query** ☐ N/A ☐ Yes **Date:**_____ ☐ No **If no please explain:** |
|---|---|

**47. Training and support is provided as part of the individual's pathway to integrated employment in accordance with DDA Policy 4.11, County Services for Working Age Adults.** ☐ Yes ☐ No **If no please explain**

**Training and supports were provided to ensure job is maintained and fading is occurring:**
**Employers:** ☐ No ☐ Yes ☐ N/A **Co-Worker:** ☐ No ☐ Yes ☐ N/A **Natural Supports:** ☐ No ☐ Yes ☐ N/A
**Provide dates and detail of training/supports and the outcome:**

**Natural Supports in place at the worksite:** ☐ No ☐ Yes ☐ N/A
**If no please include strategies for developing natural supports**

**If yes please provided first name(s) of the natural support people:**

**Fade out schedule in place:** ☐ No ☐ Yes ☐ N/A **Please explain**

**48. Changes in family situation since last plan:**
**Individual:** ☐ Married ☐ No change
**Parent(s):** ☐ Became disabled ☐ Retired ☐ Passed away ☐ No change

**49. Safety protection based upon the environment the individual is working or receiving services in**: ☐ Yes ☐ No
Does employer/environment have a health and safety plan for employees**?** ☐ Yes ☐ No ☐ N/A
**a)** Are there regular drills and/or safety procedures? ☐ Yes ☐ No
**b)** Individual knows what to do and where to go in the event of a flood/tsunami? ☐ Yes ☐ No
**c)** Individual knows what to do and where to go if they hear fire alarm or see a fire? ☐ Yes ☐ No
**d)** Individual knows what to do and where to go if there is an earthquake?: ☐ Yes ☐ No
**e)** Individual knows what to do if they get hurt while at work? ☐ Yes ☐ No
**f)** Individual knows the correct way to lift something heavy? ☐ Yes ☐ No
**g)** Individual has natural supports to go to in the event of an emergency? ☐ Yes ☐ No If so, who?_____

## 50. SUMMARY OF SERVICES

**Summary of the individual's current Employment/Community Inclusion services:**

## 51. PREVIOUS SIX MONTHS: Report from ***00/00/0000*** to ***00/00/0000***: *List the goal(s) from the previous plan, enter what was the result or outcome for the goal, mark the element that best fit that goal, and check the status for the goal.*

**a) Goal #1/Performance Indicator:**

**b) Outcome**:

**c) Status:** ☐ Completed ☐ Continued ☐ Modified ☐ Deleted

**a) Goal #2/Performance Indicator: :**

**b) Outcome:**

**c) Status:** ☐ Completed ☐ Continued ☐ Modified ☐ Deleted

## 52. MEASURABLE GOALS TO BE ACHIEVED IN THIS PLAN PERIOD

**a) GOAL #1:**

**b) Time Frame for Completion:**

**c) Goal/Service is in accordance with Developmental Disabilities Administration Employment Activities-Strategies and Progress/Outcome Measures document** ☐ Yes ☐ No ☐ N/A Community Inclusion
**Elements:** ☐ Intake ☐ Discovery ☐ Assessment ☐ Job Prep ☐ Job Development ☐ Job Coaching ☐ Job Retention

**d) Strategies to be used by the individual:**

**e) Strategies to be used by Employment/Community Inclusion Specialist:**

**f) Strategies to be used by others (DVR, family, residential staff, natural supports)**: (if not utilized explain why)

**g) Performance Indicator:**

**h) Goal/Service relate/align with the individual's DDA Person Centered Service Plan (PCSP)** ☐ Yes ☐ No
**Please explain the activity, frequency and type of support:**
**If No Please explain:**

**i) The services provided are:**

**Integrated into the greater community and supports the person having full access to the greater community**
☐ Yes ☐ No **If no please explain:**
**Ensures the individual receives services in the community to the same degree of access as individuals not receiving Supported Employment/Day Program services**
☐ Yes ☐ No **If no please explain:**
**Providing opportunities to seek employment and work in competitive integrated settings; and the setting facilitates individual choice regarding services and supports and who provides them.**
☐ Yes ☐ No **If no please explain:**
**Identifying settings that isolate people from the broader community or that have the effect of isolating individuals from the broader community of individuals who do not receive Medicaid HCB services.**
☐ Yes ☐ No **If no please explain:**

**j) Community Inclusion goal(s) must select the type of Supports Intensity Scale (SIS) subscale that relates to the community inclusion goal(s):** ☐ N/A (Not Applicable) ☐ Community Living ☐ Lifelong Learning
☐ Health and Safety ☐ Social Activities ☐ Protection and Advocacy ☐ Employment

**k) Community Inclusion goal(s) relate to the below County Guide to Achieve Developmental Disability Administration Guiding Values:** ☐ N/A ☐ Yes ☐ No **If no please explain**

☐ Identify Integrated community places ☐ Identify clubs, associations, and/or organizations

☐ Identify opportunities to contribute to the community ☐ Building & Strengthening relationships

**l) Community Inclusion activity:** ☐ N/A (Not Applicable) **The individual:**

- Participates in typical and integrated activities, events and organizations in the individual's neighborhood or local community in ways similar to others of same age ☐ Yes ☐ No
- Takes part in activities on an individual basis ☐ Yes ☐ No
- Has the opportunity for connection and relationship building between the individual and people without disabilities who are not paid to provide services to the individual. This also includes the development of natural supports and fading of paid staff support ☐ Yes ☐ No

**a) GOAL #2:**

**b) Time Frame for Completion:**

**c) Goal/Service is in accordance with Developmental Disabilities Administration Employment Activities-Strategies and Progress/Outcome Measures document** ☐ Yes ☐ No ☐ N/A (Not Applicable) Community Inclusion

**Elements:** ☐ Intake ☐ Discovery ☐ Assessment ☐ Job Prep ☐ Job Development ☐ Job Coaching ☐ Job Retention

**d) Strategies to be used by the individual:**

**e) Strategies to be used by Employment/Community Inclusion Specialist:**

**f) Strategies to be used by others (DVR, family, residential staff, natural supports):** (if not utilized explain why)

**g) Performance Indicator:**

**h) Goal/Service relate/align with the individual's DDA Person Centered Service Plan (PCSP)** ☐ Yes ☐ No

**Please explain the activity, frequency and type of support:**

**If No Please explain:**

**i) The services provided are:**

**Integrated into the greater community and supports the person having full access to the greater community**

☐ Yes ☐ No **If no please explain:**

**Ensures the individual receives services in the community to the same degree of access as individuals not receiving Supported Employment/Day Program services**

☐ Yes ☐ No **If no please explain:**

**Providing opportunities to seek employment and work in competitive integrated settings; and the setting facilitates individual choice regarding services and supports and who provides them.**

☐ Yes ☐ No **If no please explain:**

**Identifying settings that isolate people from the broader community or that have the effect of isolating individuals from the broader community of individuals who do not receive Medicaid HCB services.**

☐ Yes ☐ No **If no please explain:**

**j) Community Inclusion goal(s) must select the type of Supports Intensity Scale (SIS) subscale that relates to the community inclusion goal(s):** ☐ N/A (Not Applicable) ☐ Community Living ☐ Lifelong Learning

☐ Health and Safety ☐ Social Activities ☐ Protection and Advocacy ☐ Employment

**k) Community Inclusion goal(s) relate to the below County Guide to Achieve Developmental Disability Administration Guiding Values:** ☐ N/A ☐ Yes ☐ No **If no please explain**

☐ Identify Integrated community places ☐ Identify clubs, associations, and/or organizations

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**l) Community Inclusion activity:** ☐ N/A (Not Applicable) **The individual:**

- Participates in typical and integrated activities, events and organizations in the individual's neighborhood or local community in ways similar to others of same age ☐ Yes ☐ No
- Takes part in activities on an individual basis ☐ Yes ☐ No
- Has the opportunity for connection and relationship building between the individual and people without disabilities who are not paid to provide services to the individual. ☐ Yes ☐ No

## CONCURRENT SERVICES DOCUMENTATION
### Developmental Disabilities Administration (DDA) & Division of Vocational Rehabilitation (DVR)

**Summary of Purpose of Concurrent Services & Supports to be provided:**

| DVR Funded Objectives: | Strategies to be used: | Responsible Staff Person: | Time frame for completion: |
|---|---|---|---|
| | | | |

**53. Other accommodations, safety, adaptive equipment and/or supports critical to achieve goal(s):**

**54. Other persons and/or entities available to assist the individual in reaching their Employment/Community Inclusion goals** (family, residential staff, natural supports, Division of Vocational Rehabilitation, etc.)**:**

**55. The individual and others, in accordance with DDA Policy 5.06 Client Rights, have been informed of:**
**Their rights**. ☐ Yes ☐ No **If no please explain**
**What services and benefits may be expected from the program** ☐ Yes ☐ No **If no please explain**
**The program's expectation of them** ☐ Yes ☐ No **If no please explain**
**Respectful staff-to-participant interactions**. ☐ Yes ☐ No **If no please explain**
**Being treated with dignity, respect and free of abuse**. ☐ Yes ☐ No **If no please explain**
**Right to Privacy**. ☐ Yes ☐ No **If no please explain**
**Safeguarding personal information** ☐ Yes ☐ No **If no please explain**

**56. Grievance Process:** Individual and/or family received and reviewed the agency grievance process. ☐ Yes ☐ No **If no please explain:**

**57. Provider attended the individual's DDA Annual Assessment:** ☐ Yes ☐ No **If no please explain**
**Date(s) job coach e-mailed case manager cc'ing the County about date of Annual Assessment:**
**Date case manager gave job coach notification of Annual Assessment:**
**Date of the individual's DDA Annual Assessment:**
**Agency staff did not attend individual's DDA Annual Assessment due to:**

## 58. REQUIRED SIGNATURES & DATES

| | |
|---|---|
| **Individual:** | **Date:** |
| **Parent/Guardian:** | **Date:** |
| **Additional Support Person (Residential, Natural Supports, etc.):** | **Date:** |
| **Person Reporting Wages to SSA:** | **Date:** |
| **Agency Representative:** | **Date:** |
| **County Representative:** | **Date:** |

**59. COPY TO:** ☐ Agency _____ (date) ☐ Case Manager _____ (date) by **County**

**60. COPY TO:** ☐ Client _____ (date) ☐ Parent/Guardian _____ (date) ☐ Additional Support Person _____ (date)

Person Reporting Wages to SSA: _____ (date) ☐ Client file: _____ (date) **by Provider**

**61.** Copy of the current annual DDA Assessment Service Summary, Details and Employment Summary or PASRR Level II Assessment is in the individual's file. ☐ Yes ☐ No **If no please explain**

_____ _____

**Date(s) requested DDA documents from the case manager via e-mail** **Date received**