STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-1123	A. BUILDING _____ B. WING _____	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Outward Bound Community Services	620 Guilford College Rd Ste B Greensboro, NC 27409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V207	10A NCAC 27G .2306 CLIENT ELIGIBILITY AND ADMISSIONS (a) Eligibility. Clients served shall be eligible for ADVP regardless of financial resources with the exception of a client whose work earnings exceed 60% of the prevailing wage over a consecutive 90-day period. Eligibility for clients in non-supported employment settings whose earnings have exceeded over 60% of the prevailing wage for over 90 consecutive days may be extended for up to one calendar year if supported employment options are not available locally and the client is ineligible for other services from the Division of Vocational Rehabilitation, or if the client's social, behavioral or vocational skill deficits preclude participation in supported employment options and results in ineligibility for other vocational rehabilitation services. The eligibility extension shall occur through the annual habilitation planning process carried out by the designated area program qualified developmental disabilities professional. Requests for the extension shall be based on a joint case review involving a representative of the involved ADVP, the local VR unit and the area program. The request shall identify the specific skill deficits precluding eligibility for supported employment or other vocational rehabilitation services and include plans for addressing these deficits. The certification extension may be reapplied for a maximum of two times only. The same criteria and procedures shall be followed in each instance of reapplication as are required for the initial extension. (b) Admissions. Each ADVP shall have written admission policies and procedures. (1) A pre-admission staffing shall be held for each client considered for admission to the ADVP. During the staffing, information shall be considered regarding the client's medical, psychological, social, and vocational histories.	V207	Plan of Correction Within the next sixty days, OBCS pre-admission staffing meeting will be held to considered each new admission. During this pre-admission staffing meeting, the followinginformation will be reviewed and considered regarding the member's needs: medical, psychiatric, psychological, substance abuse, social, and vocational histories. During the pre- admission staffing meeting(s), OBCS will provide special accommodation on an "as needed basis". The outcome from this meeting shall be document and the outcome communicated with the referral agency, guardian and member. OBCS qualified personalwill be responsible for the documenting this meeting. OBCS Executive Director and/or designated staff will provide oversight to ensure that meeting(s) are held and properly document in the file by reviewing all new admission files within 60 days of admission. Target Date for Completion: December 10, 2021 the Plan of Correction	Dec 10, 21

Division of Health Service Regulation

Trishonda Patrick Trishonda Patrick — TITLE: Executive Director — (X6) DATE: 10.9.21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-1123	A. BUILDING _____ B. WING _____	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Outward Bound Community Services	620 Guilford College Rd Ste B Greensboro, NC 27409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V112	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and **(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.**	V112	As a continual of care and continuation of admission, OBCS will document all pre-admission assessment on the newly revised initial treatment plan. The results of the pre-admission will be documented in the initial treatment plan with updates as needed for pre-admission. To ensure that member is accurately assessed pre-admission, OBCS has revised its "initial treatment plan" and introduced a new "Vocational Profile" form for ADVP. The initial treatment plan has been revised to clearly list the presenting diagnoses. In addition, OBCS will use the "Vocational Profile" in conjunction with the "initial treatment plan to assess member's skills and as a tool for member development in ADVP. The member's vocational profile is an active document and will be updated as least annual with member's plan, however, will be updated as the needs of the member changes. The member, direct support staff, and qualified professional will be responsible for completion of the Vocational Profile. The qualified professional is responsible for the completion of the Initial Treatment Plan. The Member Plans which include Annual Treatment Plan and the Vocational Profile will be reviewed and updated annually by the qualified professional. However, these plans are active plan, and will be review and updated as the member's need changes. Within the next 90 days, Qualified Professional staff will complete and train Direct Support Staff on the Vocational Profile. Target Date for Completion: January 10, 2021	Jan 10, 2021

Division of Health Service Regulation

Trishonda Patrick Trishonda Patrick TITLE Executive Director (X6) DATE 10.9.2021

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

INITIAL TREATMENT PLAN

☐ **Initial** ☐ **Annual Plan** ☐ **Update Updated PCP Effective Date_____**

Outward Bound Community Services/ MCO/LME / Name & Contact Number

Please use the correct diagnosis from the latest version of DSM/ICD classification system

Date: **DIAGNOSES**		**Class: Principal (P) = Admitting/Provisional Diagnosis Primary (PR) = Current Diagnosis (es) Additional (A) = Not focus of Tx**	
Code	**Class**	**Description**	**End Date**

MCO (please check the box of the corresponding MCO):

☐ Cardinal
☐ Partners
☐ Sandhills
☐ Eastpointe
☐ Alliance
☐ Vaya
☐ Trillium

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

Date Implement: _____

INITIAL SCREENING FORM

DOB: ____/____/____ Sex: ☐ M ☐ F SSN_____/_____/_____

Ethnicity: ☐ Not Hispanic ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Unknown

Race: ☐ Black ☐ White ☐ American Indian, Alaskan Native ☐ Asian ☐

Other_____

Mailing Address_____

City_____State_____ Zip Code_____

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____

Referral Source Name and Phone _____

Presenting Problem/Need

_____

_____

_____

_____

Client Disposition

_____

_____

_____

_____

_____

_____

Basic Physical Medical Information

Date of last physical_____ Date last seen by physician_____

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

Name of Physician_____

Telephone Number _____

Address

_____

Health Problems

_____

_____

_____

Current Medications	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication allergies_____

Please document any pertinent medical information i.e. special diet, allergies, seizures, etc.

_____

_____

_____

Assessment Summary

Is agency able to provide _____ to client?

☐ Yes ☐ No (*Fill out and sign Agency Ability to Provide Services form*)

If needed, would your family

- Be supportive of your treatment? ☐ Y ☐ N
- Be willing to participate in your treatment? ☐ Y ☐ N

If recommended,

- Would you benefit from treatment? ☐ Y ☐ N
- Be willing to participate in treatment? ☐ Y ☐ N

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

Referrals:

☐ Diagnostic Assessment

With whom? _____

Appointment Date (if known) _____

☐ Outpatient Therapy

With whom? _____

☐ Other _____

What agency or resource?

_____

Other Professionals Involved

MH, DSS, GAL, Therapist, etc. (name, agency, telephone number);

1. _____
2. _____
3. _____
4. _____

Staff Signature (QP) _____ **Date**_____

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

Participants in Plan Development:

Strengths:

Needs:

Services to be initiated: Day Support Services _____

Goal: _____ will have a Person-Centered Plan (PCP)/Individual Support Plan (ISP) developed and implemented.

Responsible: Qualified Professional **Target date:** _____

Strategies: Outward Bound Community Services will work with the individual named above and family/ legally responsible person to ensure that a Person-Centered Plan-Short Term Goals is developed and implemented. Qualified Professional will facilitate assessment of services and support needs, and will facilitate team meetings to develop a Person-Centered Plan-Short Term Goals. Outward Bound Community Services will assist individual/legally responsible person in timely manner after development of a Person-Centered Plan-Short Term Goals.

_____ _____
Qualified Professional Date

_____ _____
Client Date

_____ _____
Legally Responsible Person Date

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

REQUEST FOR ACCOMMODATIONS/REMOVAL OF BARRIERS

Date: _____

Descriptions of Requested Accommodation or Barrier:

Description of Proposed Solution:

Decision:

Person Responsible for Implementation:

_____

Time Frame for Implementation, if Applicable:

_____

Date Due: _____

Date Completed: _____

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

Substance Abuse History

Substance Use

☐ Consumer denies current and/ or previous substance abuse or
☐ Substance Abuse History as follows:

	Name of Substance and Code (a)	Age at 1st Use (b)	Freq. of Use Code (c)	Route of Use Code (d)	Average Amount per day (e)	Date Last Used (f)
1st						
2nd						
3rd						
Other						
Other						

(a) Major Substance(s) Abused Prior to admission:

00-None, 01-Alcohol, 02-Cocaine/Crack, 03-Marj/Hash, 04-Herion, 05-Non. Pres. Methadone, 06-Other, Opiates/Synth., 07-PCP, 08-Other Halluc., 09- Methamp., 10-Oth. Amphet, 11-orth. Stimul, 12-Benzod., 13-Orth.

(c) Frequency of Substance Use:

0-not used past month, 1-used 1 to 3x past month, 2-used 1 to 2x per wk, 3-used 3 to 6x per week, 4-daily use

(d) Usual Route of Admission: 1-Oral, 2-Smoking, 3-Inhalation, 4-Injection, 5-Other

NAME		RECORD NUMBER	
DOB		MEDICAID ID	

SUBSTANCE ABUSE EVALUATION AND ASSESSMENT

(Applicable only to females)

Assessment Continued...

Instruction: If any of the following apply to female consumers requesting SA services, this assessment must be completed at the time of initial contact or shortly thereafter:

☐ Pregnant
☐ Caregiver of minor children

Need Assessment	Yes	No	N/A
1. Are the consumer's primary medical care needs being addressed including if pregnant, prenatal care?			
2. Are the consumer's children receiving needed primary medical care?			
3. Has gender specific treatment been considered for this consumer?			
4. Are the consumer's children receiving needed therapeutic interventions?			
5. Does the consumer have adequate transportation resource to get to and from substance abuse services?			
6. Does the consumer have needed childcare services?			

Comments:

*Any needs identified (as indicated by any "no" response to any item) must be addressed in the consumer's plan.

Note: If assistance cannot be offered to a pregnant consumer within 14 days of initial referral, alert supervisor so that Excel Personal Development can make referral to the State Capacity Management Program.

Assessed By: _____ Date: _____

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: Medicaid ID #: Record #:

VOCATIONAL PROFILE

Vocational Profile Initial Start Date: *Vocational Profile Initial Completion Date:*

Work Skills/ Info

1) If you could design the perfect job for you, your "dream job," what would it be?
2) What are your long-term career goals?
3) What is the most satisfying job you have ever had?
4) What type of job(s) do you think you would like to have now?
5) What is it that appeals to you about that type of work?
6) How long would you like to keep your next job?
7) How have you found jobs in the past?
8) Where do you want the team to job develop for you?
9) What other vocational services have you used (e.g., Vocational Rehabilitation, Work First, ESC, Temp Agencies)?
10) Are you currently receiving Vocational Rehabilitation Services? Yes ☐ No ☐ **Counselor?** N/A
11) Is the individual a potential Vocational Rehabilitation Referral? Yes ☐ No ☐
12) What type of job(s) do you know that you would NOT want?
    Fast food or in the food industry period. I don't want a driving job because I have no license or a job that do not hiring felons.
13) Do you know people who are working? Yes ☐ No ☐
    a. **What types of jobs?** Working in public services, my mom works with clients that are disabled or special needs, my dad works in a factory, I have friends that make money other ways.
    b. **What do you think about those jobs?** I think these jobs are good for them.
14) **What concerns, if any, do you have about going to work?** Not really nothing except my background but I think my charges will be reduced to misdemeanors. I don't want any job that involves physical labor or heavy lifting
15) **Work Goal related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:**

Section Update (Date:):
Section Update (Date:):

Education

1) What school did you attend last? What was the highest grade you completed?
2) How did you do in school?
3) Did you have an IEP in school? Yes ☐ No ☐ If Yes, answer (a.) below:
    a. What accommodations did you receive (i.e.- extra time on tests, reading out loud)?
4) What did you like about school?
5) What did you dislike about school?
6) Were you ever enrolled in vocational training classes? If so, what type of classes?
7) Do you have any certificates or licenses related to work?
8) Are you interested in going to school or attending vocational training to advance your work career? Yes ☐ No ☐

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: **Medicaid ID #:** **Record #:**

9) If yes, what would you like to study?

10) Education related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Work Experience & Job Start/ Stop Documentation
*(** Add additional job content rows if needed**)*

1) Most recent/ Current Job:

- *Job title:*
- *Employer:*
- *Job duties:*

Start Date: *End Date:*

- *How many hours per week?*
- *Rate of Pay:*
- *What did you like about job?*
- *What did you dislike?*
- *Reason for leaving job?*
- *If employed in this role during DSP Services:*
  - *Please describe disclosure preference.*
  - *Work Schedule:*
  - *Supervisor Name:*
- If this role ended during DSP Services:
  - *Please describe any changes in future disclosure preference:*
  - *What lessons did you learn or other information was important about this job for us to know when looking at securing and maintaining future jobs over time?*
  - *Client perspective on what led to Job End:*
  - *DSP comments on Job End:*
  - *Employer Comments on Job End (if disclosure is allowed):*

2) Most recent/ Current Job:

- *Job title:*
- *Employer:*
- *Job duties:*

Start Date: *End Date:*

- *How many hours per week?*
- *Rate of Pay:*
- *What did you like about job?*
- *What did you dislike?*
- *Reason for leaving job?*
- *If employed in this role during DSP Services:*
  - *Please describe disclosure preference.*
  - *Work Schedule:*
  - *Supervisor Name:*
- If this role ended during DSP Services:
  - *Please describe any changes in future disclosure preference:*
  - *What lessons did you learn or other information was important about this job for us to know when looking at securing and maintaining future jobs over time?*
  - *Client perspective on what led to Job End:*
  - *DSP comments on Job End:*
  - *Employer Comments on Job End (if disclosure is allowed):*

3) Next most recent job:

- *Job title:*
- *Employer:*
- *Job duties:*
- *Start Date:* *End Date:*
- *How many hours per week:* *Rate of Pay:*
- *What did you like about job?*
- *What did you dislike?*
- *Reason for leaving job?*

4) Next most recent job:

- *Job title:*
- *Employer:*
- *Job duties:*
- *Start Date:* *End Date:*
- *How many hours per week:* *Rate of Pay:*
- *What did you like about job?*
- *What did you dislike?*
- *Reason for leaving job?*

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: **Medicaid ID #:** **Record #:**

• *If employed in this role during DSP Services:* ○ *Please describe disclosure preference.* ○ *Work Schedule:* ○ *Supervisor Name:* • If this role ended during DSP Services: ○ *Please describe any changes in future disclosure preference:* ○ *What lessons did you learn or other information was important about this job for us to know when looking at securing and maintaining future jobs over time?* ○ *Client perspective on what led to Job End:* ○ *DSP comments on Job End:* ○ *Employer Comments on Job End (if disclosure is allowed):*	• *If employed in this role during DSP Services:* ○ *Please describe disclosure preference.* ○ *Work Schedule:* ○ *Supervisor Name:* • If this role ended during DSP Services: ○ *Please describe any changes in future disclosure preference:* ○ *What lessons did you learn or other information was important about this job for us to know when looking at securing and maintaining future jobs over time?* ○ *Client perspective on what led to Job End:* ○ *DSP comments on Job End:* ○ *Employer Comments on Job End (if disclosure is allowed):*

Work Experience related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Military Experience

1) Have you ever been in the military? Yes ☐ No ☐ What branch?
2) What did you do in the military? Did you receive any training or certifications?
3) What years were you in the military?
4) What type of discharge did you receive?
5) Military related information from family, friends, previous employers, behavioral health, or other supports:

Section Update (Date:):

Education Experience Report
*(** Add additional Education content rows if needed**)*

School or training program #1:	School or training program #2:
• *Degree or Certificate sought:*	• *Degree or Certificate sought:*
• *Start date: Full-time or part-time:*	• *Start date: Full-time or part-time:*
• *Date person exited the school/training program:*	• *Date person exited the school/training program:*
• *Degree/Certificate Obtained:*	• *Degree/Certificate Obtained:*
• *Reason that person left the school/training program, including graduation:*	• *Reason that person left the school/training program, including graduation:*
• *Supports provided by Direct Support Professional:*	• *Supports provided by Direct Support Professional:*
• *Support provided by office for students with disabilities:*	• *Support provided by office for students with disabilities:*
• *Obstacles encountered/how did person overcome obstacles?*	• *Obstacles encountered/how did person overcome obstacles?*
• *Future education goal:*	• *Future education goal:*

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: **Medicaid ID #:** **Record #:**

• *Lessons learned for future education or job experiences:*	• *Lessons learned for future education or job experiences:*

Cultural Information/ Preferences

1) What is important to you in terms of your background and culture? (Note: if the individual is unsure what is meant by this question, provide a few examples such as race, ethnicity, color, gender, economic status.)
2) What different languages do you speak? What language do you prefer?
3) What special events or holidays do you celebrate? Are there family traditions that you\still practice? How would you like your family involved as we move forward in the process of getting and keeping a job?
4) Is it important to you whether your work supervisor is male or female? How so?
5) Have you ever felt discriminated against or treated unfairly when you were looking for work or on the job? Could you tell me about that?
6) Who would you like involved as you look for a job?
7) What is the best way to contact each of these people?
8) Cultural Information/ Preferences related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Mental Health

1) Has anyone ever told you that you have a mental illness? If so, what did they say?
2) What are the first signs that you may be experiencing symptoms?
3) How do you cope with your symptoms?
4) How do the medicines work for you?
5) What side effects, if any, do the medications cause?
6) Mental Health related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Physical Health

1) How would you describe your physical health?
2) Do you have any problems with the following?
   a. Standing for long periods? Yes ☐ No ☐ How long can you stand?
   b. Sitting? Yes ☐ No ☐ How long can you sit?
   c. Climbing stairs? Yes ☐ No ☐ how many flights? How often?
   d. Lifting? Yes ☐ No ☐ How Much?
3) How is your endurance? How many hours could you work each day? Each week?
4) Any problems with temperature extremes (hot or cold)?
5) Any problems with exposure to chemicals, dust, allergens, etc.?
6) Any allergies?
7) Physical Health related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: Medicaid ID #: Record #:

Section Update (Date:):
Section Update (Date:):

Cognitive Areas

1) Do you have problems with memory? Explain.
2) Concentrating/staying focused? Explain.
3) Doing things fast (psychomotor speed)? Explain.
4) If so, what things have helped with these issues in the past?
5) Cognitive related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Getting Ready for Work; Identification of Barriers

1) Do you have the clothes you will need for a job? For interviews?
2) Do you have an alarm clock or way to wake up at a certain time for work?
3) Do you have two forms of ID? Picture ID, social security card, birth certificate…?
4) What is the best way for an employer to contact you (phone, email, text)?
5) How might you get to a job (bus, car, walk, etc.)?
6) Is it harder for you to get a job or to keep a job? Why do you think this is so?
7) Do you usually know if you will keep the job within the first few days/weeks? Yes ☐ No ☐ *If yes, how?*
8) Barrier related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Interpersonal Skills

1) How well do you get along with other people?
2) Would you like a job that involved working with the public? If not, why?
3) Where do you live and with whom do you live?
4) Is your current housing stable, safe, and secure? Yes ☐ No ☐ *If not, why?*
5) Who do you spend time with? How often do you see or talk to them?
6) Who might be a good person to help think about good jobs for you?
7) Once you are employed, who would be a good person to support you?
8) Anyone else?
9) Interpersonal Skill related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: **Medicaid ID #:** **Record #:**

Benefits

Which of the following benefits do you receive? Not applicable ☐

a)	SSI, SSDI, Housing Subsidy, Food Stamps, TANF, etc. **Yes** ☐ **No** ☐ Details:
b)	Retirement from previous job **Yes** ☐ **No** ☐ Details:
c)	VA benefits **Yes** ☐ **No** ☐ Details:
d)	Spouse or dependent child receives benefits? **Yes** ☐ **No** ☐ Details:
e)	Medicaid/ Medicare or Other benefits: **Yes** ☐ **No** ☐ Details:
f)	I'm not sure what my benefits are:
g)	No benefits **Yes** ☐ **No** ☐ Details:
h)	Do you have a payee? **Yes** ☐ **No** ☐ Details:
i)	Referral made to benefits planner. **Yes** ☐ **No** ☐ (If no referral, why not:) In process, Direct Support Professional will refer me to a peer who can help me with some food benefits. Date of referral and name of benefits counselor: Date of benefits counseling appointment: **Remember to get a copy of the written benefits counseling report to put in the person's chart/file.**
j)	Do you have a pending disability claim? Have you been denied disability benefits? **Yes** ☐ **No** ☐ Details:

Benefit related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Follow Along Supports (During Job Development and VR Milestones 1 & 2)

1) **What supports might you need to be successful in maintaining employment?**
   - a. **Help with transportation:** Yes ☐ No ☐ Details:
   - b. **Help with social skills on the job:** Yes ☐ No ☐ Details:
   - c. **Interventions with employers and/or co-workers:** Yes ☐ No ☐ Details:
   - d. **Dress and grooming:** Yes ☐ No ☐ Details:
   - e. **Assistance with job changes:** Yes ☐ No ☐ Details:
   - f. **Support and Problem Solving:** Yes ☐ No ☐ Details:
   - g. **Help with managing/reporting benefits:** Yes ☐ No ☐ Details:
   - h. **Money management:** Yes ☐ No ☐ Details:
   - i. **Medication adjustments:** Yes ☐ No ☐ Details:
   - j. **On the job coaching:** Yes ☐ No ☐ Details:
   - k. **Family support and education:** Yes ☐ No ☐ Details:
   - l. **Help with attendance:** Yes ☐ No ☐ Details:
   - m. **Other:** Yes ☐ No ☐ Details:
2) **What friends or family might be helpful in supporting you gaining employment?**
3) **How will the person(s) help?**
4) **What might the DSP Team be able to do as we work with you to prepare those individuals to support you?**
5) **Follow along support related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:**

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: Medicaid ID #: Record #:

Section Update (Date:):
Section Update (Date:):

Follow Along Supports (To be completed after job start, VR Milestone 3)/ Indefinite Supports Plan for Vocational Rehabilitation

1) What supports might you need to be successful in maintaining employment?
   a) Help with transportation: Yes ☐ No ☐ Details:
   b) Help with social skills on the job: Yes ☐ No ☐ Details:
   c) Interventions with employers and/or co-workers: Yes ☐ No ☐ Details:
   d) Dress and grooming: Yes ☐ No ☐ Details:
   e) Assistance with job changes: Yes ☐ No ☐ Details:
   f) Support and Problem Solving: Yes ☐ No ☐ Details:
   g) Help with managing/reporting benefits: Yes ☐ No ☐ Details:
   h) Money management: Yes ☐ No ☐ Details:
   i) Medication adjustments: Yes ☐ No ☐ Details:
   j) On the job coaching: Yes ☐ No ☐ Details:
   k) Family support and education: Yes ☐ No ☐ Details:
   l) Help with attendance: Yes ☐ No ☐ Details:
   m) Other: Yes ☐ No ☐ Details:
2) What strengths will help you succeed on the job?
3) What do you want to get out of the job?
4) How will you know if the job is a good fit for you?
5) What friends or family might be helpful in supporting you maintaining employment?
6) How will the person(s) help?
7) What might the DSP team be able to do as we work with you to prepare those individuals to support you?
8) If open with Vocational Rehabilitation, what is the stabilization date for starting the 30-60-90-day count?
9) Follow along support related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Education Supports Plan (If applicable)

1) What supports might you need to be successful in completing your educational/certificate/training program?
   a. Help with transportation: Yes ☐ No ☐ Details:
   b. Help with social skills with peers: Yes ☐ No ☐ Details:
   c. Interventions with teachers: Yes ☐ No ☐ Details:
   d. Dress and grooming: Yes ☐ No ☐ Details:
   e. Assistance with schedule/assignment changes: Yes ☐ No ☐ Details:
   f. Support and Problem Solving: Yes ☐ No ☐ Details:
   g. Help registering with disability/student services: Yes ☐ No ☐ Details:
   h. Help requesting accommodations (e.g., more time to take tests, access to notes from assigned note-taker, permission to record class sessions): Yes ☐ No ☐ Details:
   i. Assistance applying for school and/or financial aid: Yes ☐ No ☐ Details:

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: **Medicaid ID #:** **Record #:**

j. Assistance registering for classes: Yes ☐ No ☐ Details:
k. Family support and education: Yes ☐ No ☐ Details:
l. Help with attendance: Yes ☐ No ☐ Details:
m. Help with study skills: Yes ☐ No ☐ Details:
n. Help with time management and organizational skills: Yes ☐ No ☐ Details:
o. Help finding clubs and activities to join: Yes ☐ No ☐ Details:
p. Other: Yes ☐ No ☐ Details:

2) What strengths will help you succeed in the education program?
3) What do you want to get out of the educational program?
4) What type of job/career do you hope to have after completing this educational program?
5) How will you know if this educational program is a good fit for you?
6) What friends or family might be helpful in supporting you complete the educational program?
7) How will the person(s) help?
8) What might the DSP Team be able to do as we work with you to prepare those individuals to support you?
9) What is the anticipate date for completing the educational program?
10) Follow along support related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Disclosure Plan for Approaching Employers (During job development)

1) What might be some of the advantages/pros of having a Direct Support Professional contact employer on your behalf?
2) What might be some of the disadvantages/con's?
3) What might be some of the advantages/pros of NOT having a Direct Support Professional contact employer on your behalf? *I really can't see any since I been working with my Direct Support Professional, but I can say that I can put in applications and get to job interviews even if I don't have a Direct Support Professional.*
4) What might be some of the disadvantages/con's?
5) Are there any things that you would NOT want your Direct Support Professional to share with an employer? Yes ☐ No ☐ If so, what do you want them NOT to share?
6) Do you know whether or not you would like your specialist to go ahead and contact employers on your behalf? (It is ok to change your mind at any time): Yes ☐ No ☐
7) If you decided that the specialist should not contact employers, what things would you like him or her to do in order to help you find a job:

Help with Job Leads: Yes ☐ No ☐	*Help with Applications:* Yes ☐ No ☐	*Help with Resume:* Yes ☐ No ☐
Transportation to interviews: Yes ☐ No ☐	*Interview Practice:* Yes ☐ No ☐	*Finding Childcare:* Yes ☐ No ☐
Discussing criminal background: Yes ☐ No ☐	*Discussing Accommodations:* Yes ☐ No ☐	*Other:*

8) If you decided that you want the DSP contacting employers, what would you want the DSP to share with an employer? *That I am interested in employment and that I can do the job.*
9) Disclosure/ approaching employer related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: Medicaid ID #: Record #:

Disclosure Plan for Speaking with the Employer (After starting the job)

1) What are some of the advantages/pros of having your Direct Support Professional to speak with your employer after you are offered employment or start the job?
2) What are some of the disadvantages/con's?
3) What are some of the advantages/pros of NOT having your Direct Support Professional speak with your employer after you are offered employment or start the job?
4) What are some of the disadvantages/con's?
5) What are some things you would want your Direct Support Professional to share with your employer (if applicable)?
6) What are some things that you would NOT want your Direct Support Professional to share with your employer (if applicable)?
7) Would you like to discuss possible job accommodations you might need for the job and how to speak to an employer about accommodations needed?
8) What things would you like for the Direct Support Professional to do in order to help you start a job:

Discussing accommodations: Yes ☐ No ☐	*Help with orientation paperwork/tax forms:* Yes ☐ No ☐	*Help with transportation:* Yes ☐ No ☐
Benefits reporting: Yes ☐ No ☐	*On-site training:* Yes ☐ No ☐	*Other:*

9) Disclosure speaking with employer related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Substance Use

1) What, if any, substances do you use? Cannabis
2) How often? Daily but not that much lately since I am trying not to smoke
3) Is there a particular time of day? In the mornings and before bed
4) Have you ever received Substance Use treatment? Yes ☐ No ☐ Details:
5) Substance use related input from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Legal History

Have you ever been arrested? Yes ☐ No ☐	Have you ever been convicted of a crime? Yes ☐ No ☐

If YES, complete the below:

Type: Year: State: Circumstances:	Type: Year: State: Circumstances:
Type:	Type:

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: Medicaid ID #: Record #:

Year: State: Circumstances:	Year: State: Circumstances:
Type: Year: State: Circumstances:	Type: Year: State: Circumstances:

Do you have pending Legal Charges? Yes ☐ No ☐ Details: *Felony breaking and entering*	Are you Currently on Probation/Parole? Yes ☐ No ☐ Details:

Legal History related input from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Daily Activity

1) What is a typical day like for you from the time you get up until you go to bed?
2) Where do you like to hang out and spend your free time? Why do you like it there?
3) What types of clubs, groups, a church are you a member?
4) What activities are you currently involved in where you use your gifts and talents to help others?
5) What kind of things do you do (hobbies or interests) that make you happy, and give you a sense of joy, satisfaction, peace, accomplishment, and personal fulfilment?
6) What are your typical sleep hours?
7) Daily Activity related input from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Networking Contacts

1) Family:
2) Friends:
3) Previous employers:
4) Vocational Rehabilitation:
5) Others:
6) Networking related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Job Search Plan

1) Employment goal (in the job seeker's own words):
2) Job seeker's strengths:

OUTWARD BOUND COMMUNITY SERVICES
Exceptional Services for Exceptional Individuals

Name: Medicaid ID #: Record #:

3) Job seeker's preferences from most to least important (e.g., hours, type of work, location, work environment, etc.):

4) Will the DSP gather information about jobs on the job seeker's behalf and advocate with employers? Yes ☐ No ☐ If so, how many businesses will the DSP visit each month?

5) Will the DSP and job seeker apply for jobs together? Yes ☐ No ☐ If so, how often will they meet with the DSP visit each month? *8 times*

6) Will the job seeker worker on finding jobs outside of the appointments with the DSP? Yes ☐ No ☐ If so, what types of jobs and/or businesses?

7) What businesses with the DSP and/or job seeker approach?
   a)
   b)
   c)
   d)
   e)

8) Job Search related information from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Transition/ Graduation Plan (Start planning during intake, but update after obtaining employment)

1) How will the DSP Team know you are ready for graduation?
2) What goals will you have accomplished?
3) If you are doing well on the job, what will that look like for you?
4) What are the important things that will help you keep the job?
5) How long do you anticipate needing DSP services after you are employed?
6) What services would you be interested in receiving after graduating from DSP?
7) From what agency would you like to receive services? (Get a signed consent)
8) What do you think your potential graduation date will be?
9) Graduation related input from family, friends, VR counselors, previous employers, behavioral health, or other supports:

Section Update (Date:):
Section Update (Date:):

Client Signature and Date

DSP Signature and Date

Qualified Professional Staff Signature and Date

Guardian/Natural Support Signature and Date