ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Employment Supports & Services

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	

See page 2 for EOE/ADA disclosures

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 _____

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