

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
 Division of Developmental Disabilities • Employment Support and Services
EMPLOYMENT SUPPORT AIDE - QUARTERLY REPORT

MEMBER'S NAME: _____ MEMBER'S DDD ID NUMBER: _____

MEMBER'S JOB TITLE: _____ MEMBER'S HIRE DATE: _____

WEEKLY WORK SCHEDULE: _____ HOUR WORKED PER WEEK: _____

QUALIFIED VENDOR NAME: _____ CONTACT PERSON NAME: _____

QUALIFIED VENDOR MAILING ADDRESS: (No., Street) _____

CITY _____ STATE _____ ZIP CODE _____

QUALIFIED VENDOR E-MAIL ADDRESS: _____

EMPLOYER'S NAME: _____ EMPLOYER'S PHONE NUMBER: _____

EMPLOYER'S ADDRESS: (No., Street) _____

CITY _____ STATE _____ ZIP CODE _____

SUPERVISOR/CONTACT PERSON'S NAME: _____

SUPPORT COORDINATOR: _____ DDD EMPLOYMENT SPECIALIST: _____

REPORT PERIOD

1st Quarter (due by April 15th)

2nd Quarter (due by July 15th)

3rd Quarter (due by October 15th)

4th Quarter (due by January 15th)

	Month / Year	Month / Year	Month / Year
Total Hours Worked			
Personal Care Service Authorized			
Personal Care Service Provided			
Behavioral Support Service Authorized			
Behavioral Support Service Provided			
Hours Job-Related Supports Authorized (only available in follow-along)			
Hours Job-Related Supports Provided (only available in follow-along)			
Member Hourly Pay Rate			

SERVICE SETTING	
	Group Supported Employment
	Individual Supported Employment
	Follow-Along Services

Routing: Original - Support Coordinator

BEHAVIORAL INTERVENTION

OUTCOME AS STATED IN THE INDIVIDUAL SUPPORT PLAN:

PROGRESS MADE ON LISTED OUTCOME(S). IF NO PROGRESS, IDENTIFY BARRIERS AND LIST PLAN OF ACTION.

FOLLOW-ALONG SERVICES

OUTCOME AS STATED IN THE INDIVIDUAL SUPPORT PLAN:

PROGRESS MADE ON LISTED OUTCOME(S). IF NO PROGRESS, IDENTIFY BARRIERS AND LIST PLAN OF ACTION.

EMPLOYMENT SUPPORT AIDE SERVICES LOG

Provide a detailed summary of services rendered, including a description of personal care activities, behavioral supports and job-related supports. Each contact entry must be signed by the Employment Support Aide. Attach additional sheets as necessary.

DATE	SERVICE HOURS	SUMMARY OF SERVICES RENDERED	EMPLOYMENT SUPPORT AIDE'S SIGNATURE

QUALIFIED VENDOR ADMINISTRATOR / DESIGNEE'S NAME *(Print)* _____

QUALIFIED VENDOR ADMINISTRATOR / DESIGNEE'S TITLE _____

QUALIFIED VENDOR ADMINISTRATOR / DESIGNEE'S SIGNATURE _____ DATE _____

