SUPPORTED EMPLOYMENT PROGRESS REPORT

PROVIDER NAME: _____ PROVIDER #: _____ SERVICE MONTH: _____ YEAR: _____

INDIVIDUAL'S NAME		MEDICAID #:	SERVICE CODE:	REPORT DATE: month / year
EMPLOYER / ADDRESS				PLAN DATE
STD.START TIME:	STD. END TIME:	SUPERVISOR:	FREQ. OF IMPLEMENTATION:	

SERVICE CODE:
SERVICE TYPE:
LOCATION CODE:

ACO: INDIVIDUAL OPTIONS WAIVER **FCO**: LEVEL ONE WAIVER **LOC**: LOCAL FUNDING
A: VOCATIONAL ASSESSMENT **B:** JOB DEVELOPMENT **C:** JOB TRAINING **D:** JOB FOLLOW ALONG **E**: OTHER
1. AGENCY **2.** INDIVIDUAL'S HOME **3.** HOSPITAL **4.** ICF / MR **5.** WORKSITE **6.** COURT **7.** OTHER

DATE	TIME IN	TIME OUT	*DURATION* # units	SERVICE TYPE	Location CODE	PROGRESS NOTES	INITIALS

Print Name: _____ Initials: _____ Signature/Date: _____

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Monthly Summary:

Print Name: _____ Initials: _____ Signature/Date: _____