Long Term Supports Plan

Person with overall monitoring responsibilities: _____ **Date Completed:** _____

Name: _____ SS#: _____

Address: _____ Telephone #: _____

_____

Employer: _____ Supervisor: _____

Address: _____ Telephone #: _____

_____ Hire Date: _____

Rehabilitation Counselor: _____ Telephone #: _____

Case Manager: _____ Telephone #: _____

Employment Specialist: _____ Telephone #: _____

School Personnel: _____ Telephone #: _____

Other: _____ Telephone #: _____

Identified Need:
Potential Options:
Customer Preference:

Primary Support:

Back-up Support:

Status **(check one):**

___ Past
___ Present
___ Future

Identification of Funding Sources **(check one):**

___ Title 19
___ Medicaid
___ MR Services
___ MH Services
___ SSA (attach
___ VR State Funding
___ Other (specify: _____

_____

Identified Need:

Potential Options:

Customer Preference:

Primary Support:

Back-Up Support:

Status **(check one)**: ___ Past ___ Present ___ Future	***Identification of Funding Source*** **(check one):** ___ Title 19 ___ MH Services ___ Medicaid ___ SSA (attach ___ MR Services ___ VR State Funding ___ Other (specify: _____)
Identified Need:	
Potential Options:	
Customer Preference:	
Primary Support:	
Back-Up Support:	
Status **(check one):** ___ Past ___ Present ___ Future	***Identification of Funding Source*** **(check one)** ___ Title 19 ___ MH Services ___ Medicaid ___ SSA (attach ___ MR Services ___ VR State Funding ___ Other (specify: _____)