B.E.S.T.

BRIDGE TO EMPLOYMENT IN SERVICE AND TOURISM

Application Purpose & Guidelines

The purpose of this application packet is to obtain a broad picture of the individual and outline the skill set of the B.E.S.T. applicant. This application enables the B.E.S.T. coordinators and selection team to properly assess each candidate's interests, skills, abilities and background. A parent, Individual Support Coordinator, direct support professional, job coach, or employer may be contacted to gather additional information. Our goal is to select candidates who will be successful in the B.E.S.T. program and reach the outcome of competitive employment.

The Selection Process includes the following guidelines:

1. All applicants are encouraged to meet the coordinator and receive more details about B.E.S.T.

2. **Submit the completed application packet via mail, email, or fax to the address on page 3 of this application packet.**

3. **All applicants MUST attend an interview and/or consultation on the day scheduled.** Please dress business casual for the interview and be prepared to perform several different job tasks.

4. The B.E.S.T. staff and internship site hosts will review the applications, and if selected, match the applicant's skill set and interests with the appropriate internship selections.

5. If selected, a Circle of Support meeting will be arranged to amend the Individual Support Plan/ Person Centered Support Plan and any associated funding.

6. **If selected, applicants MUST pass a criminal background check and drug screen before the first day of the program.**

B.E.S.T. Application Packet Checklist

PLEASE NOTE
ALL THE REQUIRED DOCUMENTS MUST BE COMPLETED AND SENT TOGETHER FOR APPLICATION TO BE CONSIDERED. IF YOU NEED ASSISTANCE COMPILING THIS INFORMATION, PLEASE CONTACT YOUR DIRECT SUPPORT STAFF OR CONSERVATOR.

Application Packets MUST include the following:

1. Completed application forms.
2. A signed copy of the Bridge to Employment in Service and Tourism (B.E.S.T.) Expectations.
3. Recommendations from your current support agency (if applicable) and a personal reference (forms included in the application packet).

Return completed application packets to:

Breakthrough Corporation
1700 Liberty Street
Knoxville, TN 37921

Email: instructor@BESTknoxville.org
Fax: 865-247-0066

Application for Admission

A. **APPLICANT PERSONAL INFORMATION:**

Name: _____
Last First Middle

SS#: _____

Address: _____
Street City Zip Code

E-mail Address: _____ Cell/Home Phone: _____

Date of Birth: _____ Male Female

B. PARENT/CONSERVATOR PERSONAL INFORMATION:

Do you have a conservator? YES NO

If yes, list name below. If no, list any family member or friend who may be assisting with your application.

Name: _____ E-mail: _____

Address: _____ _____
Street City/State Zip Code

Cell/Home Phone: _____ Work Phone: _____

B.E.S.T.
BRIDGE TO EMPLOYMENT IN SERVICE AND TOURISM

C. APPLICANT/CONSERVATOR ACKNOWLEDGMENT AND APPROVAL:

1. Selection into the B.E.S.T. Program is dependent upon program and host site review.

2. By signing below you agree to release all information on this application for the purpose of discussion during the program and host site review.

3. By signing below you also authorize the B.E.S.T. program to use your name, photograph and any video-recorded activities for media presentations related to B.E.S.T. activities.

4. Equal Opportunity: Program decisions regarding acceptance and placement will be made without regard to race, color, national origin, sex, age, religion, or presence of a disability.

A two-week trial period will be required of all candidates who are accepted into the B.E.S.T. program. The conservator and applicant agree to comply with this procedure.

Applicant Signature: _____ Date: _____

Conservator Signature: _____ Date: _____

D. AGENCY RECOMMENDATION: *Section D to be completed by agency staff member* (if applicable)

Applicant's Name: _____

Applicant's Agency/School: _____

Why do you think this person is a good candidate for B.E.S.T.?

_____

_____

_____

Comments about attendance:

_____

_____

_____

Comments about long-term employment interests:

_____

_____

_____

Comments regarding work performance:

_____

_____

_____

Print Name: _____
Signature: _____
Title: _____
Agency Affiliation: _____
Phone/Email: _____

B.E.S.T.
BRIDGE TO EMPLOYMENT IN SERVICE AND TOURISM

E. PERSONAL RECOMMENDATION: *Section E to be completed by a personal reference*

Applicant's Name: _____

Why do you think this person is a good candidate for B.E.S.T.?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Print Name: _____

Signature: _____

How do you know the applicant?: _____

How long have you known the applicant?: _____

Phone/Email: _____

F. EMPLOYMENT INTERESTS AND BACKGROUND:

When you are hired for paid employment do you want to work full time or part time?
Please check both if applicable: Full-time: Part-time:

Which shift would you prefer working after completing B.E.S.T.? Check all that apply:

Early AM	Mid Day	Night shift
Day shift	Evening shift	Overnight

List jobs you do or have done while in school or in the community (if any). List most recent first:

Start Date:	Employer:		Paid Employment:	**Yes**	**No**
	Supervisor:		Contact Number:		
End Date:	Task 1:		Task 2:		
	Task 3:		Task 4:		

Start Date:	Employer:		Paid Employment:	**Yes**	**No**
	Supervisor:		Contact Number:		
End Date:	Task 1:		Task 2:		
	Task 3:		Task 4:		

Start Date:	Employer:		Paid Employment:	**Yes**	**No**
	Supervisor:		Contact Number:		
End Date:	Task 1:		Task 2:		
	Task 3:		Task 4:		

Have you ever been fired from, let go from or asked to resign from a job? Have you ever quit a job?

Yes No

If yes, please explain:

____

____

What do you consider to be the biggest barrier to employment?

If yes, please explain:

____

____

G. UNIFORM:
Please provide shirt size for uniform ordering purposes.

Shirt Size: _____
Amount Requested: _____

Shirt color: Purple

H. TRANSPORTATION:
How do you plan to get to B.E.S.T. internship?

Self Agency KAT/ lift Family Other

I. SERVICE AGENCIES:

Do you have a Vocational Rehabilitation Counselor? (VR Counselor)? If yes, please provide:
Yes Name _____ Phone Number: _____
No

Do you have an Independent Support Coordinator through the Department of Intellectual and Developmental Disabilities (DIDD)? If yes, please provide:

Yes Name _____ Phone Number: _____
No

Do you have a Support Coordinator through the Employment and Community First Choices Program (ECF) and a Managed Care Organization (MCO) such as Amerigroup, BlueCare, United Healthcare? If yes, please provide:

Yes Name _____ Phone Number: _____
No

Do you have some other service not listed above? If yes, please provide:
Yes Name _____ Phone Number: _____
No

J. ACCOMMODATIONS:

Do you have any challenges or limitations that would require accommodations?

K. APPLICANT RESPONSE QUESTION:
Why do you want to participate in B.E.S.T.? (*Complete in your own words or have someone write your thoughts for you, using your own words*)

L. PREPARER:
If this application has been completed by someone other than the applicant, please provide the following information and sign:

Name	Title	Phone Number	Date

Signature

B.E.S.T.
BRIDGE TO EMPLOYMENT IN SERVICE AND TOURISM

M. SAMPLE B.E.S.T. INTERN CONTRACT:

The intern will be asked to sign the B.E.S.T. contract AFTER selection into the program.

I, Intern's Name, understand that I have been accepted into the B.E.S.T. program and must abide by the following terms and conditions:

- I understand that the desired outcome for me in B.E.S.T. is full/part-time paid employment in the community.
- I will actively pursue employment during the internship experience.
- I will complete at least two unpaid job rotations within a host business (ORNL).
- I will attend the program five days a week for 7 hours per day (e.g. 8:00am - 3:00pm), Monday through Friday, understanding that internship times may change based on the internships I select.
- I will maintain professional behavior appropriate to my work environment.
- I will participate in any training or certification processes required to complete my job duties as an intern.
- I will call my instructor and departmental supervisors when I will be absent or tardy.
- I will make up any time missed due to absences.
- I will learn to use public transportation if at all possible.
- I will follow all the policies and procedures established by the program and host business.
- I will dress according to the dress code and uniform requirements of the assigned host site and/or rotation.
- I will attend weekly Employment Planning Meetings with my Instructor and Job Coach; I will be an active participant and communicate any issues at the meetings.
- I will attend scheduled Staffing reviews with my Instructor, Job Coach, VR Counselor, Independent Support Coordinator, and family supports. I will be an active participant and communicate any issues at the meetings which will be held at least twice during my internship.
- I will work with my personal and community supports to obtain the supplies from the supply list for my site. (List is distributed at the Host Site Orientation)
- I will receive a Bridge to Employment in Service and Tourism certificate of completion when I complete the program.

I authorize B.E.S.T. to use my name, photograph, and any video-recorded activities in media presentations in regards to my participation in B.E.S.T. activities.

I have read the above terms and conditions and agree to accept my placement in the B.E.S.T. program. I understand that I may be asked to leave B.E.S.T. if I fail to follow the terms and conditions. ********For information only. Signature not required at this time. ********

_____ _____

Intern Signature *Date*

_____ _____

Parent/Conservator Signature *Date*

_____ _____

B.E.S.T. Team Member Signature *Date*

B.E.S.T.
BRIDGE TO EMPLOYMENT IN SERVICE AND TOURISM

N. ACKNOWLEDGMENT OF B.E.S.T. EXPECTATIONS

- Be 18 yrs or older
- Have the desire and plan to work competitively in the community at the conclusion of the B.E.S.T. internship
- Meet eligibility requirements for Pre-Employment Transitional Program and/or Vocational Rehabilitation and/or DIDD and/or ECF Choices Program
- Have independent personal hygiene and grooming skills
- Have independent living skills
- Maintain appropriate behavior and social skills in the workplace. Such behaviors as violence, aggression, physical harm, sexually inappropriate behaviors, theft and/or destruction of property will not be allowed.
- Take direction from supervisors and change behavior as needed
- Be able to communicate effectively
- Have no more than 3 “unexcused absences” (an “excused” absence would include medical appointments with a doctor’s note, or family crises such as death or medical emergency)
- Pass drug screen and felony check

I acknowledge the expectations above

_____

Applicant /Date

autism BREAKTHROUGH OF KNOXVILLE

Breakthrough Pre-Planning and Consent Forms for ISP Meetings

_____ **Title VI confirmation**

_____ **Breakthrough Person Supported Grievance Procedure**

_____ **Consent/Release for Healthcare Treatment**

_____ **Informed Consent Letter (Only if HRC Restrictions needed)**

_____ **Photo/Video Release**

_____ **Psychotropic Medication Consent** (Only if Breakthrough is passing meds and they take psychotropic meds)

_____ **Seizure Protocol** (Write N/A if no seizure diagnosis)

_____ ~~**Housing Options Form** (Only for Community Living)~~

_____ **Breakthrough Supported Employment ISP Planning Form**

_____ **Updated Contact List**

_____ ~~**ISP Meeting Note**~~

_____ **Release to Contact Employer**

_____ **Policy Receipt**
Volunteer/Intern Consent
Current Lease signed
Budget updated
_____ **Emergency Data Form updated**

autism BREAKTHROUGH OF KNOXVILLE

Rights, Eligibility, Planning, Grievances and Appeals Information

Department of Disability and Aging (DDA) Website:
https://www.tn.gov/disability-and-aging.html. This website has the entire Medicaid Waiver Operations Manual and other information about DDA for your reference. The information below was taken from this website:

Rights Applicable to All People with Disabilities: People with intellectual and developmental disabilities have the same rights as other people unless their rights have been limited by court order or law. Individuals do not give up their rights when they accept services from DDA or other state programs. There are basic human and civil rights that are protected by the constitution and state and federal laws. Many of the laws take the form of protecting people from discrimination. The Americans with Disabilities Act is an example of such a law. People with intellectual and developmental disabilities should be treated fairly and equally when service are being developed and provided.

Individual Rights: DDA persons supported shall be entitled to the following rights without limitation:

1) To be treated with respect and dignity as a human being
2) To have the same legal right and responsibilities as any other person unless otherwise limited by law
3) To receive services regardless of gender, race, creed, marital status, national origin, disability or age
4) To be free from abuse, neglect and exploitation
5) To receive appropriate quality services and supports in accordance with the Individual Support Plan (ISP)
6) To receive services and supports in the most integrated and least restrictive setting that is appropriate based on the Person's particular needs
7) To have access to DDA rules, policies and procedures pertaining to services and supports
8) To have access to personal records and to have services, supports and personal records explained so they are easily understood
9) To have personal records maintained confidentially
10) To own and have control over personal property, including personal funds
11) To have access to information and records pertaining to expenditures of funds for services provided
12) To have choices and make decisions
13) To have privacy
14) To receive mail that has not been opened by provider staff or others
15) To be able to associate, publicly or privately, with friends, family and others

16) To have intimate relationships with other people of their own choosing
17) To practice the religion or faith of one's choosing
18) To be free from inappropriate use of physical or chemical restraint
19) To have access to transportation and environments used by the general public
20) To be fairly compensated for employment
21) To seek resolution of rights violations or quality of care issues without retaliation

☐ **The Right to Have a Provider of Your Choice and to have Grievances Addressed:** The individual has the right to choose from a list of available providers of services. If the individual is not satisfied with the services provided by an agency, they should try to resolve the concern with the agency. Each agency that provides services through the DDA program has a policy for addressing grievances of the individual. You should be provided with a copy of their Grievance Policy. At any time, the individual can ask their Independent Support Coordinator (ISC) for assistance in resolving the concern. If the ISC cannot help, the person or family can file a complaint. **A complaint can be filed at any time through the DDA Division of Customer Focused Services, DDA Regional Office, the DDA Central Office, or at TennCare.** Telephone numbers are: East Tennessee – 1-888-310-4613, Middle Tennessee – 1-800-535-9725, TennCare DLTC – 1-877-224-0219.

DDA Division of Customer Focused Services
Dr. Michael Mailahn, CFS Coordinator & Rule 31 Mediator 1-865-320-2196 Mike.Mailahn@tn.gov
Jerry Winters, CFS Coordinator 1-423-787-6526 Jerry.Winters@tn.gov

Medicaid Waiver Appeals: If a person has a complaint about services through the Statewide Waiver, Managed Care Organization, Behavioral Health Organization, or pharmacy, an appeal can be filed. This can be done if services are denied, delayed, changed organization some way or some event impacts the quality, timeliness, or availability of the service. When this happens, the state will send a letter outlining the right to appeal, how to appeal and how long the person has to begin the appeal. **The ISC can assist you with an appeal if this is desired. Questions about an appeal can be directed to the ISC or to the Bureau of TennCare Solutions Unit at 1-800-878-3192.**

Concerns Related to Abuse, Neglect or Mistreatment: Report to East – 1-800-579-0023, Middle – 1-888-633-1313, West – 1-888-632-4479.
Title VI of the Civil Rights Act of 1964: Title VI of the Civil Rights Act of 1964 prohibits discrimination in programs that utilize federal funds. Medicaid waivers are an example of programs that are partially funded with federal dollars. The Department of Intellectual and Developmental Disabilities (DDA), as well as providers who sign provider agreements with DDA, must comply with Title VI requirements. DDA and DDA providers must not exclude persons, deny benefits to or otherwise discriminate against applicant for services or persons served based on race, color or national origin in the admission to or participation in any of its programs and activities. Prohibited Practices: Prohibited practices include but are not limited to the following:

1) Denying any service, opportunity or other benefit for which an applicant or person supported is otherwise qualified

2) Providing any applicant or person supported with any service or other benefit which is different or is provided in a different manner from that which is provided to others in the same program
3) Subjecting any person supported to segregated or separate treatment in any manner related to the receipt of service
4) Restricting any person supported in any way in the employment of services, facilities or any other advantage, privilege or benefit provided to others in the same program
5) Adopting methods of administration that would limit participation or subject any group of applicants or persons supported to discrimination
6) Addressing an applicant or person supported in a manner that denotes inferiority because of race, color or national origin
7) Subjecting any applicant or person supported to racial or ethnic harassment, to a hostile racial or ethnic environment or to a disproportionate burden of environmental health risks

A Title VI complaint may be filed by a person supported, a person's family member, a person's legal representative, a support coordinator/case manager or other entity acting on the person's behalf. The person supported or other entity filing the complaint need not be the victim of discrimination. Title VI complaints may be submitted in writing to the Local (provider) Title VI Coordinator, the DDA Regional Office Title VI Coordinator or the DDA Central Office Title VI Coordinator @ Department of Health and Human Services Office of Civil Rights located in Atlanta @ 404-562-7881. A person filing a Title VI complaint has the right to file the complaint with the federal Office of Civil Rights at any stage of the complaint process. All Title VI complaints filed with the U.S. Department of Health and Human Services must be filed no later than 180 calendar days after the alleged discrimination occurred. Complaints may be filed by letter or by completing the Title VI Complaint Form.

Responsibilities: Along with rights, there are certain responsibilities and requirements that persons supported and their families must understand. State and federal Medicaid law specifies that:

1) A physical examination must be completed every 1 to 3 years as required
2) A form must be completed each year to document the need for continuing waiver services
3) Financial information must be provided each year for annual redetermination of the Medicaid financial eligibility
4) The person supported and family are required to allow state and federal staff to visit them at home, talk with them and their staff, and review their personal records for the

purpose of assessing the quality of services being delivered and the persons supported safety in the community

5) The person supported/family will be visited in the home several times a year by the ISC to ensure that the ISP is being implemented
6) The person supported/legal representative will be asked to participate in the selection of the Circle of Support members and will be invited to and encouraged to participate in the ISP planning meetings. Additionally, DDA requires that a uniform assessment be completed at least every two years for all DDA persons supported

Items 4, 5 and 6 above apply to state funded persons supported also.

The ISP and the Planning Process: The Individual Support Plan (ISP) is person-centered in that it provides an individualized, comprehensive description of a person supported, as well as guidance for achieving unique outcomes that are important to the person in achieving a good quality of life in the community. The ISP is "owned" by the individual. Consequently, the individual is to be encouraged and supported to participate in the planning process to the extent that he/she chooses. The individual may be assisted in planning supports and services by a "Circle of Support".

The Circle of Support (COS) is a group of individuals who meet or otherwise share information on a regular basis to help a person served accomplish personal life goals and become an active member in the community. The individual or their legal representative is in control of who participates as a member of the COS and how the COS functions. The individual may change COS membership at any time. The Independent Support Coordinator (ISC) can facilitate a COS by distributing invitations/meeting announcements and other materials to COS members. It is best for the ISC to be present to facilitate the planning process during COS meetings. In addition to the individual, other supports such as parents/legal representative, natural supports, agency staff, and anyone else who is chosen by the person supported and agrees can participate as a COS member. If provider staff is invited to participate in the COS, their primary focus must be on supporting the individual, not on representing the provider. Situations in which provider staff use the role as a COS member to coerce or influence the selection of service options must be avoided.

RECEIPT OF INFORMATION

My signature below indicates that I have received a copy of the above information and that it has been reviewed with/by me.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

autism BREAKTHROUGH OF KNOXVILLE

Breakthrough Person Supported Grievance Procedure

This procedure is established to safeguard the personal and legal rights of the person supported and provide a process of review for any complaints the person supported or representative has with the agency's service delivery. Retaliation against anyone filing a complaint to Breakthrough or DDA will not be tolerated. Decisions arising from local, state, or federal laws will not be handled under this procedure.

1. Complaints must be filed within thirty days of an act or event with which a person supported or representative is dissatisfied. A complaint may be filed with the Executive Director/ Compliant Resolution Coordinator.
2. The Executive Director/ Compliant Resolution Coordinator will be responsible for securing all facts pertinent to the issues. They will also hear and evaluate evidence and construct a record to permit a prompt and equitable decision for mutual resolution.
3. The aggrieved person may formally or informally present the complaint to the Executive Director/ Compliant Resolution Coordinator who will review the matter promptly and impartially and respond within seven (7) working days, with final resolution being achieved within thirty (30) days.
4. If the person is not satisfied with the answer he/she receives from the Executive Director/ Compliant Resolution Coordinator, a complaint can be filed at any time through the DDA Division of Customer Focused Services, DDA Regional Office, the DDA Central Office, or at TennCare.

   Telephone numbers are:
   East Tennessee – 1-888-310-4613, Middle Tennessee – 1-800-535-9725, TennCare DLTC – 1-877-224-0219

   DDA Division of Customer Focused Services
   Dr. Michael Mailahn, CFS Coordinator & Rule 31 Mediator
   1-865-320-2196 Mike.Mailahn@tn.gov
   Jerry Winters, CFS Coordinator
   1-423-787-6526 Jerry.Winters@tn.gov

   Breakthrough Executive Director/Complaint Resolution Coordinator
   Kendrise Colebrooke
   1-865-247-0065, ext. 25 kcolebrooke@breakthroughknoxville.org

autism BREAKTHROUGH OF KNOXVILLE

RECEIPT OF GRIEVANCE PROCEDURE

My signature below indicates that I have received a copy of the **Breakthrough Grievance Procedure** and that I understand how to file a grievance.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

autism BREAKTHROUGH OF KNOXVILLE

Consent/Release for Healthcare Treatment

I give permission for Breakthrough to provide or to obtain all medical services for the person supported, _____, required by the state of Tennessee in order to perform the services required for which he/she receives funding while in Breakthrough's care.

In case of emergency, and in the event that myself or _____ **(if applicable)** cannot be reached, I hereby consent for the above named person supported to receive health care deemed necessary and advisable from the physician for the health and well-being of the above named individual including, but not limited to medical, dental, hospital, psychiatric and other treatment under the direction of Breakthrough Corporation.

I authorize the release (and receipt) of any medical information necessary to process the treatment for any medical assessments, evaluations, coordination of care, procedures, medications, or applicable insurance claims. In addition, if applicable, I request payment of government benefits to the party who accepts assignments.

I authorize payment of nursing or medical benefits as approved by the State or other entities to the provider of services as deemed necessary by Breakthrough Corporation.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

I understand that I do not have to sign this documentation form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To comply with Breakthrough and State of Tennessee DDA requirements
- To effectively coordinate care between separate entities

If the person supported has only Personal Assistance (PA) Services or Day Services (DS) please sign below to indicate you do not wish for Breakthrough to be involved in these activities.

I decline the release for healthcare treatment and information because my person supported receives only DS or PA Services.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

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Informed Consent Letter

I, _____, give my consent to the following Human Rights Restrictions. I understand this consent is valid for one year and will be requested again when the Human Rights Committee (HRC) meets to discuss this restriction. I also understand that at any time I may rescind this consent by notifying the Incident Management Coordinator in writing.

☐ New Restriction

☐ Annual Restriction Review

-
-

I have been invited to the HRC meeting discussing the following restrictions. It is scheduled on _____ at _____.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

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Photo/Video Release

I, _____, give Breakthrough permission to photograph or video _____. I authorize Breakthrough Co. and Breakthrough's community partners to use and publish those photographs or videos in print or electronically.

I agree that Breakthrough and/or community partners may use such photographs for any lawful purpose, including but not limited to staff training, visual supports, publicity, marketing, social media and web content.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

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Psychotropic Medication Consent

_____'s medical practitioner(s) have prescribed the following medications.

Medication	Dose	Diagnosis	Physician	Therapeutic Range

By signing below I acknowledge I have been given opportunity to review the above medication(s). I give my consent for the use of the listed medication(s). I understand that I can reevaluate the need for any of these medication(s) at any time.

Verbal consent obtained on _____ by _____.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

autism BREAKTHROUGH OF KNOXVILLE

Seizure Protocol

Name: _____ Date: _____

Doctor: _____

The Person Supported pre-seizure signs can be described as:_____

_____

The Person Supported seizure can be described as: _____

_____

Other: _____

_____

_____

_____

Instructions:

- ☐ Call 911 if the seizure last more than _____ minutes.
- ☐ Call 911 if Person Supported has more than _____ seizures in a row.
- ☐ Call 911 immediately.
- ☐ Other instructions you wish to be followed in the event of a seizure: _____

  _____

  _____

  _____

  _____

- ☐ If you want medication to be administered please write an order and attach to this protocol (Please be very specific with parameters. Our staff cannot make judgment calls).

Physician Signature: _____ Date:_____

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Person Supported: _____ISP Meeting Date: _____

Section A: (Complete if the person supported IS currently interested in employment)

1. Do you currently have an open VR case? YES NO
2. If so, who is your VR counselor? _____
3. Are you interested in attending the BEST Program? YES NO
4. Are you interested in attending Project SEARCH? YES NO
5. What types of employment or job opportunities interest you?

   _____ _____

   _____ _____

   _____ _____

6. What types of skills or vocational topics would you like to learn more about this year?

   _____ _____

   _____ _____

   _____ _____

Section B: (Complete if the person supported is NOT currently interested in employment)

1. Are you currently engaged in volunteer opportunities? YES NO
2. If so, what are those opportunities and what tasks are performed/learned:

   _____

   _____

   _____

3. If no, what are some areas of interest regarding future volunteer opportunities:

   _____

   _____

   _____

4. Has Breakthrough completed a Supported Employment Plan of Action Meeting for you?
   YES NO
5. If no, would you like an SE POA meeting scheduled in the next 3 months?
   YES NO
6. In what specific ways can Breakthrough begin and/or continue Discovery with you:

   _____

   _____

   _____

_____ _____

Breakthrough Representative Date

autism BREAKTHROUGH OF KNOXVILLE

Making Sense of Supported Employment
FAQ Sheet

What is the Breakthrough Supported Employment Program?
What a person does for a living is an enormously important part of one's identity and how one fits into their world and communities. Unfortunately, many people with disabilities think they are not qualified to work or do not have the support necessary to achieve and maintain successful employment. The Breakthrough Supported Employment Program seeks to break down the barriers and misperceptions that surround employment for individuals with disabilities by providing various programs and avenues of support. We offer employment placement, resume writing workshops, one-on-one vocational coaching, employment classes, and job coaching. We sincerely believe that every single person who desires an opportunity for competitive wage employment should be given a chance to achieve their goals.

What is Vocational Rehabilitation?
Vocational Rehabilitation is a State run program under the direction of the Department of Human Services. This program offers qualified agencies the funding to work with persons with disabilities to assist them in finding employment. The first step in the process of the Breakthrough Supported Employment Program is to open an employment case with VR. This can be done through Breakthrough Corporation as a referral, or a family or individual can contact the program directly. For details and VR contact information, please visit www.tennessee.gov/humanserv/rehab/vrs.html.

What is a Breakthrough Supported Employment Plan of Action Meeting?
Plan of Action Meetings are designed to offer support to the Breakthrough Residential staff and the Breakthrough Day Services staff. These meetings are scheduled and facilitated by the Breakthrough Supported Employment Director. Through communication and formal goal development, a plan of action is put in place to help each individual served reach their vocational goals.

What is Discovery?
Discovery is the process of getting to know the interests, strengths, preferences and skill level of those we support through the use of various tools such as home visits, interviews, observation, etc. Discovery is an important step in the vocational and placement process.

What is the BEST Program?
The Bridge to Employment in Service and Tourism (B.E.S.T.) project provides career exploration in the hospitality, service and tourism industry through onsite training and placement in a hospitality, service or tourism setting for working-aged adults with significant disabilities and barriers to employment.
Our 16 week internship is hosted primarily at the Oak Ridge National Laboratory, with some rotations hosted by partners in the greater Knoxville metropolitan area.
Interns complete 3 weeks of orientation, 2-3 rotations in community integrated work place environments to increase skills for competitive employment, then spend the remaining 4 weeks seeking employment; all with the help of our Work-Based Learning Staff.

What is Project SEARCH?
Project SEARCH is a nationally recognized program originally started at Cincinnati Children's Hospital. This is a 9-month internship program in which individuals experience 3, 10-week internships in a hospital setting in order to gain hands on employment skills and vocational classroom instruction. Breakthrough currently runs a Project SEARCH program at the University of Tennessee Medical Center. Enrollment for this program begins each fall with a new internship class beginning each winter.

For more information about the Breakthrough Supported Employment Program, please feel free to contact our ECF Coordinator at mwarwick@breakthroughknoxville.org or 865-440-4356.

autism BREAKTHROUGH OF KNOXVILLE

Updated Contact List

Person Supported: _____

Parent/Conservator/Guardian

Name(s) _____
Address _____
_____
Phone Numbers _____
_____
Email _____
_____

ISC

Name(s) _____
Address _____
_____
Phone Numbers _____
_____
Email _____

Natural Supports

Name(s) _____
Address _____
_____
Phone Numbers _____
_____
Email _____

Therapy Provider

Name(s) _____
Agency _____
Address _____
_____
Phone Numbers _____
_____
Email _____

Therapy Provider

Name(s) _____
Agency _____
Address _____
_____
Phone Numbers _____
_____
Email _____

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RECEIPT OF POLICIES AND PROCEDURES

My signature below indicates that I have received a copy of the following policies and procedures:

- Individual Rights, Respect, Dignity, and Privacy
- Board of Director Policy
- Complaint Resolution/Grievance Procedure Policy

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

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Volunteer/Intern Consent

I give my consent for volunteers or interns who have direct interaction with me to read and be trained on my ISP and ITSP as well as any therapy plans deemed necessary. Volunteers and Interns will NOT take the place of paid supports.

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____

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Release to Contact Employer

I, _____, give Breakthrough Supported Employment Staff permission to communicate with employers on my behalf during my job search for some or all of the following reasons:

- ☐ Contact or speak with employers on my behalf regarding employment
- ☐ Complete and submit applications
- ☐ Attend interviews with job seeker
- ☐ Participate in training
- ☐ Speak with employers about my disability, if deemed necessary

Disclaimer: We at Breakthrough will not do or say anything that we feel will negatively impact the chances of obtaining employment. We will not disclose any information that you do not wish to be shared.

I Do NOT want the following information to be disclosed during employment search and maintained by anyone other than myself:

_____

_____

_____

Individual Name: _____

Individual Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Individual: _____