Employment Addendum

Data Field	Client Information
Person's Name (First, MI, Last)	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
Record Number	Record agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/ Program Name	Record the organization and program for whom you are delivering the service.
DOB	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.

Data Field	Employment Addendum
Current Employment	Check all boxes that apply to record person's employment status.
Is person served satisfied with job	Check the appropriate box.
Is person's served job in jeopardy	Check the appropriate box. It is at the discretion of the agency as to whether or not to contact the person's supervisor if person's job is in jeopardy.
Not in Labor Force	If the person is not in the labor force, record the date last worked and check all boxes that apply to the person's situation.
Is the person concerned that employment will effect current benefits	Check the appropriate answer. If yes, explain the reason.
Name of Most Recent Employer	Identify the company name of the person's most recent employer, if any.
Reason(s) for Leaving Jobs in the Last 5 Years	Check all boxes that apply for all jobs in last five years, if any. Check Not Applicable (NA) if the person hasn't worked in the last 5 years.
Attendance	If the person has worked in the last 5 years, check the box that applies.
Performance	If the person has worked in the last 5 years, check the box that applies.
Comments	Can be used for any additional comments.

Data Field	Signatures
Person's Signature (Optional, if clinically appropriate)	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.

Clinician/Provider – Print Name/Credential	**Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor – Print Name/Credential (if needed)	If applicable, **legibly** record signature and credentials of supervisor.
Date	Date of this signature.
Clinician/Provider Signature	**Legible** signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature (if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date	Date of this signature.
Physician/MD/DO Signature (if required)	**Legible** physician's signature if required by agency policy. Please note certain payers do require physician's signature. This is a requirement for Opiate Treatment Programs