Job Placement Services

958X-Community Work Experience

<table>
<thead>
<tr>
<th>AV#:</th>
<th>(7 digits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCES-VR ID#:</td>
<td>(6 digits)</td>
</tr>
<tr>
<td>CAMS ID #:</td>
<td>(10 digits)</td>
</tr>
</tbody>
</table>

VR District Office: ____________________________ Provider: ____________________________

VRC Name: ____________________________ NYS Fiscal System ID: ____________________________

Report Date: ____________________________

Participant First Name: ____________________________ Participant Last Name: ____________________________

Participant Phone Number: ____________________________ Participant Email Address: ____________________________

This serves as a reimbursement request for minimum wage, not the prevailing wage if different, plus an administrative cost for payroll issues for up to 320 hours of paid work experience.

Start Date of Work Experience:

Anticipated Completion Date of Work Experience:

Indicate Last Date of Contact if Drop Out Applies:

Employer-based Work Experience Business Name:

Work Experience Business Location:

Anticipated Work Experience Schedule:

Please indicate why the employer was unable or unwilling to place the ACCES-VR participant on their payroll.

Number of hours utilized for this report:
Duplicate paystubs must be attached and should reflect the above number of hours submitted in this report.

**Total hours utilized to date:**

The vendor is responsible for withholding federal, state, local tax (in some locations) and Federal Insurance Contributions Act (FICA) which includes Social Security and Medicare taxes.

**Completed By:**

______________________________________________
Signature

______________________________________________
Date

______________________________________________
Printed Name

______________________________________________
Title

Phone Number:

______________________________________________
Email: