AV #:	**(7 digits)**
ACCES-VR ID #:	**(6 digits)**
CaMS ID #:	**(10 digits)**

SUPPORTED EMPLOYMENT
571X – Intake

AV:
Main Frame ID #:
CaMS ID: (10 digits)

VR District Office:	Provider:
VR Counselor Name:	Report Month: Month: Year:

Consumer Name:
Consumer Phone Number:
Consumer Email Address:

INITIAL ASSESSMENT

1. Can you assist this individual in finding employment? ☐ Yes ☐ No

2. Are there any assets/barriers related to disability that you need to discuss with the VRC prior to the development of the VR Individualized Service Plan?
   ☐ Yes ☐ No

3. If you do not accept this individual for services, please provide the reason. In your review, please take into consideration any concerns with functional limitations related to their disability and the effect on their vocational goal.

4. Please list next steps, including next scheduled appointment.

Comments/Next Steps/Next Appointment:

_____
Signature of Provider

_____
Title

_____
Date