VR-571X

Supported Employment

571X-Intake

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

VR District Office:	Provider:
VRC Name:	NYS Fiscal System ID:
Intake Date:	Report Date:

Participant First Name:	Participant Last Name:
Participant Phone Number:	
Participant Email Address:	

INITIAL ASSESSMENT

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

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

3. If you do not accept this individual for services, please explain:

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

Comments/Next Steps:

5. Date Referral Received:

Form Revised Date: 11/1/18

6. Was this report completed and submitted within the required 20 days from the receipt of authorization? ☐ Yes ☐ No
   If No, please explain and maintain adequate supporting documentation in the participants file.

8. Date of next appointment:

Completed By:

Qualified Staff Signature	Date
Printed Name	Title
Phone Number:	Email: