

**Supported Employment**

**572X-Pre-Employment Assessment/Job Development**

VR-Intensive Services Plan

|  |  |  |
| --- | --- | --- |
| AV#: | (7 digits) | Click to enter |
| ACCES-VR ID#: | (6 digits) | Click to enter |
| CAMS ID #: | (10 digits) | Click to enter |

|  |  |  |  |
| --- | --- | --- | --- |
| VR District Office:  | Click to enter | Provider: | Click to enter |
| VRC Name: | Click to enter | NYS Fiscal System ID: | Click to enter |
|  | Report Date: | Click to enter |

|  |  |  |  |
| --- | --- | --- | --- |
| Participant First Name: | Click to enter | Participant Last Name: | Click to enter |
| Participant Phone Number: | Click to enter |
| Participant Email Address: | Click to enter |

|  |  |
| --- | --- |
|  |  |
| 1. | Employment Goal(s): |
|  | a. | Job title(s) | Click to enter  |
|  | b. | Geographic location | Click to enter  |
|  | c. | Work environment | Click to enter |
|  |  | \* If enclave or mobile work crew add justification |
|  |  | Click to enter  |
|  |  |
| 2. | How many hours per week would the participant like to work?  |
|  | Click to enter |
|  | If the participant’s goal is to work less than 30 hours per week, please indicate the reason(s): |
|  |[ ]  Unable to work 30 hours due to limitations directly related to disability. Explain (utilize referral information): |
|  | Click to enter |
|  |[ ]  Participant is not seeking 30 hours or more |
|  |[ ]  Concern about loss of benefits  |
|  |[ ]  Other, please explain: |
|  | Click to enter |
|  |  |
| 3. | Preferred work schedule: |
|  | Click to enter |
|  | Is the participant available for evening and/or weekend shifts? If they are not, list the specific reason(s): |[ ]  Yes |[ ]  No |
|  | Click to enter |
|  |  |
| 4. | List individual’s wage expectation: |
|  | Click to enter |
|  | If the per hour wage expectation is below minimum wage, please explain why: |
|  | Click to enter |
|  |  |
| 5. | Did the participant attend benefits advisement? |[ ]  Yes |[ ]  No |
|  | If no, does the participant require benefits advisement prior to employment?  |[ ]  Yes |[ ]  No |
|  |  |  |  |  |  |
| 6. | Does the participant understand the effect of income on benefits? Explain:  |  |  |
|  | Click to enter |  |  |  |  |
|  |  |  |  |  |  |
| 7. | Does the provider recommend the VRC refer the participant for Benefits Advisement? |[ ]  Yes |[ ]  No |
|  |  |
| 8. | Will a PASS Plan be necessary? |[ ]  Yes |[ ]  No |
|  |  |
| 9. | List the individual’s key strengths/skills as observed or described in the referral, then apply them in your strategies below.  |
|  | Click to enter |
|  |  |  |  |  |  |

**Individualized Employment Related Barriers and Strategies:**

PLEASE BE SPECIFIC IN DESCRIBING EMPLOYMENT RELATED BARRIERS AND INDIVIDUALIZED STRATEGIES.

|  |  |
| --- | --- |
| **Barrier** | **Strategies** |
| **1.** | Click to enter | **1.** | Click to enter |
|  | **2.** | Click to enter |
|  | **3.** | Click to enter |
| **2.** | Click to enter | **1.** | Click to enter |
|  | **2.** | Click to enter |
|  | **3.** | Click to enter |
| **3.** | Click to enter | **1.** | Click to enter |
|  | **2.** | Click to enter |
|  | **3.** | Click to enter |
| **4.** | Click to enter | **1.** | Click to enter |
|  | **2.** | Click to enter |
|  | **3.** | Click to enter |

Additional pages may be included if more barriers and strengths exist.

**Employment Activities and Supports Services:**

PLEASE DESCRIBE PLANNED ACTIVITIES

These activities conducted by the service provider are required to be for a minimum of five hours monthly. This **must** include direct engagement with the participant as well as job development with potential employers.

|  |
| --- |
| **Activities/Supports** |
| Click to enter |

Additional pages may be included

|  |  |
| --- | --- |
| 10. | Which agency will be the Extended service funding source? |
|  |[ ]  OMH |
|  |[ ]  OPWDD |
|  |[ ]  ACCES-VR |
|  |[ ]  ACCES-VR Extended Supported Employment for Youth |
|  |[ ]  OPWDD Application Pending (Specify current status): |
|  | Click to enter |
|  |  |
| 11. | Provide details regarding the need for long-term supports. Include anticipated needs and expectations for use of natural supports.  |
|  | Click to enter |

Is an off-site waiver being requested?

|  |  |  |
| --- | --- | --- |
|[ ]  Yes |[ ]  No | If yes, provide justification below. |
|  | Click to enter |

Discussed with and agreed to by ACCES-VR VRC on the date listed below (Provider must maintain documentation of this in participant record):

|  |  |  |
| --- | --- | --- |
|[ ]  Yes |[ ]  No | Click to enter |
|  |  |  |  | Date |

|  |  |  |
| --- | --- | --- |
| This plan has been discussed with each of the partners listed below and they agree to the outline above. (Provider must maintain documentation of this in participant record) |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Participant Signature: |  | Date: |  |

|  |
| --- |
| **Completed By:**  |
|  |  | Click to enter |
| Qualified Staff Signature |  | Date |  |
| Click to enter |  | Click to enter |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |

|  |
| --- |
|  **Provider Supervisor:**  |
|  |  | Click to enter |
| Qualified Staff Signature |  | Date |  |
| Click to enter |  | Click to enter |
| Printed Name |  |  | Title |  |

Please indicate the names of **all** individuals who will receive a copy of this plan.

|  |  |
| --- | --- |
| Click to enter | Click to enter |
| Click to enter | Click to enter |
| Click to enter | Click to enter |