Supported Employment

572X-Pre-Employment Assessment/Job Development

VR-Intensive Services Plan

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

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

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

1. Employment Goal(s):
   a. Job title(s)
   b. Geographic location
   c. Work environment
      * If enclave or mobile work crew add justification

2. How many hours per week would the participant like to work?

   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):
   - ☐ Participant is not seeking 30 hours or more
   - ☐ Concern about loss of benefits
   - ☐ Other, please explain:

Form Revised Date: 11/1/18

3. Preferred work schedule:

   Is the participant available for evening and/or weekend shifts? ☐ Yes ☐ No
   If they are not, list the specific reason(s):

4. List individual's wage expectation:

   If the per hour wage expectation is below minimum wage, please explain why:

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:

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.

Individualized Employment Related Barriers and Strategies:

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

Barrier	Strategies
	1.
	2.
	3.
	1.
	2.
	3.
	1.
	2.
	3.
	1.
	2.

	3.

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

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):

11. Provide details regarding the need for long-term supports. Include anticipated needs and expectations for use of natural supports.

Is an off-site waiver being requested?

☐ Yes ☐ No If yes, provide justification below.

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 _____
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:

Qualified Staff Signature Date

Printed Name Title

Phone Number: Email:

Provider Supervisor:

Qualified Staff Signature Date

Printed Name Title

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