

**Supported Employment**

**582X- Extended Supported Employment for Youth**

|  |  |  |
| --- | --- | --- |
| 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 |

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

|  |  |
| --- | --- |
|  |  |
| Participants Date of Birth: | Click to enter |
|  |  |
| Date Participant Turns 25: | Click to enter |
|  |  |
| Date of Entry into Extended Services: | Click to enter |
|  |  |
| Date of 48 months from Date of Entry: | Click to enter |
|  |  |

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|  |  |  |  |  |  |  |  |  |
| **Report Month/Year:** | Click to enter | Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Name of Employer:** | Click to enter |
|  |  |
| **Employer Address:** | Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Job Title:** | Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Essential Functions of the Job:** | Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Work Schedule/Weekly Hours:** | Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Hourly Wage:** | Click to enter |

**Participant Contact**

Report each event and duration of service. Additional service dates and time can be attached.

|  |  |  |
| --- | --- | --- |
| **Date** | **Face to Face**(amount of time) | **Email, Phone**(amount of time) |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
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| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| **Total** | Click to enter | Click to enter |

**Employer Contact**

Report each event and duration of service or check the box below if the individual has not disclosed his or her disability to the employer.

[ ]  N/A - The individual has not disclosed his or her disability to the employer

|  |  |  |
| --- | --- | --- |
| **Date** | **Face to Face**(amount of time) | **Email, Phone** (amount of time) |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| Click to enter | Click to enter | Click to enter |
| **Total** | Click to enter | Click to enter |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **Work Performance Observed:** |  |  |  |  |  |  |
| Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Participant Satisfaction/Feedback:** |
| Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Long Term Support Provided During the Report Month (Check all that apply):** |
|[ ]  Work Readiness Skills |[ ]  Symptom Management |[ ]  Natural Supports |
|[ ]  Work Related Social Skills |[ ]  Work/Life Balance |[ ]  Problem Solving |
|[ ]  Coping Skills |[ ]  Conflict Resolution | [ ]  | Worksite Accommodations |
|[ ]  Job Attendance |[ ]  Personal Appearance |[ ]  Transportation |
|[ ]  Interpersonal Relationships (employer, supervisor, co-workers) |[ ]  Benefits Monitoring (Social Security, Medicaid, housing, food stamps, etc.) |[ ]  Changes in Employment Situation (new management, response to performance review, changes in job tasks) |
|[ ]  Changes in Community Living Arrangements |[ ]  Other: | Click to enter |[ ]  Other: | Click to enter |
|  |  |  |  |  |  |
| **Additional Comments/Concerns:** |  |  |  |  |  |  |
| Click to enter |
|  |  |  |  |  |  |  |  |  |  |

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| --- |
| **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 |  |