

**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 |

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

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| --- | --- |
|  |  |
| 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 | | | | | | | | | | | | | |
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| **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 |
| 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 |  |