Supported Employment

582X- Extended Supported Employment for Youth

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

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

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

Participants Date of Birth:

Date Participant Turns 25:

Date of Entry into Extended Services:

Date of 48 months from Date of Entry:

Report Month/Year:

Name of Employer:

Employer Address:

Job Title:

Essential Functions of the Job:

Form Revised Date: 11/1/18

Work Schedule/Weekly Hours:

Hourly Wage:

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)
Total		

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)
Total		

Work Performance Observed:

Participant Satisfaction/Feedback:

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:	☐ Other:

Additional Comments/Concerns:

Completed By:

Qualified Staff Signature ____________________ Date ____________________

Printed Name ____________________ Title ____________________

Phone Number: Email:

Provider Supervisor:

Qualified Staff Signature ____________________ Date ____________________

Printed Name ____________________ Title ____________________

Form Revised Date: 11/1/18