VR-575X (5/14)

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

SUPPORTED EMPLOYMENT

Job Retention Services Report

575X – Job Retention

AND

Extended Services

Job Retention and Career Development Plan

***Quality Bonus payments must be claimed on Form 576X and/or 577X.**

Section 1: Employment Details

Provider Name:

NYS Fiscal System #:

Consumer Name:

Consumer DOB: Consumer SS #:

Job Title:

Business Name (Employer):

Name of Supervisor:

Start Date of Employment:

Date 90-Day Milestone was Achieved:

Work Schedule/Hours:

Wages:

Benefits:

Type of Employment: Community, Enclave, Mobile Crew, Other
Describe:

Use of Hiring Incentives: Tax Credit, WTO, OJT, Other
Describe:

Section 2: Performance

		Yes	No
1.	Have there been any changes in job tasks since day 45? List changes:	☐	☐

2. Overall, are you satisfied with the individual's performance? ☐ ☐
   Explain:

3. Does the individual:

   A. Satisfactorily perform job tasks? ☐ ☐
   B. Maintain satisfactory attendance? ☐ ☐
   C. Demonstrates punctuality? ☐ ☐
   D. Communicate well with co-workers? ☐ ☐
   E. Communicate well with supervisor? ☐ ☐

Comments: Please describe any additional areas of concern that are not listed above:

4. Job Task Achievement Levels (list top 4)

1.	☐ Limited ☐ Average ☐ Above Average ☐ Excellent
2.	☐ Limited ☐ Average ☐ Above Average ☐ Excellent
3.	☐ Limited ☐ Average ☐ Above Average ☐ Excellent
4.	☐ Limited ☐ Average ☐ Above Average ☐ Excellent

Comments:

Section 3: Barriers and Strategies

1. List ongoing needs to retain employment and strategies to meet those needs (Review 574X – Job Placement Day 45 Report):

Barrier	Strategies
1.	1.
	2.

	3.
2.	1.
	2.
	3.
3.	1.
	2.
	3.
4.	1.
	2.
	3.

2. Describe long term natural supports already in place (or being developed) and how they will assist in job retention (or in intermittent services):

Natural Support	How Does This Assist in Job Retention
1.	1.
	2.
	3.
2.	1.
	2.
	3.
3.	1.
	2.
	3.
4.	1.
	2.
	3.

3. Does the individual know who to contact should any issues arise? ☐ Yes ☐ No
   List Name:

4. Does individual understand the effect of income on benefits? ☐ Yes ☐ No
   Comments:

5. Is the individual interested and is there an opportunity to accomplish growth in wages or hours? ☐ Yes ☐ No

   If Yes, outline the plan for achieving one or both of these quality levels (30 hours per week or hourly wage of $9.50 Upstate and $10.50 Downstate) within the next 6 months.

Section 4: Consumer Satisfaction

(Provider should assist the individual in completion of the job satisfaction survey below.)

	Yes	No
A. Are you satisfied with your job?	☐	☐
B. Do you have any problems getting to work each day?	☐	☐
C. Do you feel you need additional help in any of your current work responsibilities?	☐	☐
D. Do you feel you have adequate opportunity to communicate with your supervisor?	☐	☐

Comments:

Section 5: Business Satisfaction

	Yes	No
1. Is the business satisfied with the individual's performance?	☐	☐
2. Has the business identified areas for improvement?	☐	☐
If Yes, has an action plan been developed to meet these expectations? Please describe in the comment section below.	☐	☐

Comments:

Section 6: Considerations

	Yes	No
1. Is there an expected need for VR services beyond extended services (i.e., tools, clothing, equipment, transportation)?	☐	☐
2. Will the individual have the opportunity to increase hours and/or wages in this position?	☐	☐
3. Will the individual have the opportunity to receive health care or other benefits from the business or other sources?	☐	☐

Please list sources and type of benefits:

Comments:

Section 7: Additional Closure Requirements

1. Are 50% or more of the individual's wages the result of a NYSID or NISH Contract?
   ☐ Yes ☐ No

2. If earning less than minimum wage, what is the individual's commensurate wage and, how was it determined? Please describe (including the expectation of reaching minimum wage):

3. Extended Funding Source will be:
   ☐ ACCES-VR ☐ OPWDD/Waiver ☐ OMH (note if PROS) ☐ Other
   Please note other source or if eligibility is pending on the above services.

The transition of this individual to extended service funding and approval for closure of this case as a successful rehabilitation confirms the final deliverable of Job Retention Services.

Additional Comments:

Extended Service Notes

- Frequency of intervention must continue at a **minimum** of two times per month;
- Waivers for off-site follow along must still be established;
- This plan may be reviewed semi-annually or if a major change occurs including any transition to Intermittent Extended or graduation from extended services.

Document the date of discussion and agreement on this plan:

_____ _____
Signature of Consumer Date

_____ _____
Signature of Provider Date

_____ _____
Signature of Provider's Supervisor Date

Discussed with and Agreed to by ACCES-VR VRC on the date listed below:

☐ **Yes** ☐ **No** _____
Date

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