



## Job Placement Services

Check Appropriate Box:

- 932X - Job Retention Services
- 937X - Job Retention Services (Deaf Service)

Authorization #	
Aware Participant ID	

VR District Office:	Vendor:
VRC Name:	SFS Vendor ID:
	Report Date:

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

<b>Job Retention Information</b> This is a Final Report Submitted for Payment	
<b>Job Title:</b> ( <i>Note:</i> Title should match IPE employment goal)	
<b>Business (Employer) Name:</b>	
<b>Business Address:</b>	
<b>Employment Start Date:</b>	
<b>Date 90-day Retention:</b>	
<b>Work Schedule / Hours:</b>	
<b>Wage Information: (pay stub)</b>	
<b>Essential Functions of the Position:</b>	
<b>Is the Customer meeting the Employer's expectations?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Medical Benefits:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Other Benefits:</b>	

VR-932/937X

Is the customer satisfied with Employment Placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the customer Agreeable to Case Closure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the customer aware that they may reapply for ACCES-VR Services if their employment situation changes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe Retention Services Provided:		
Additional Comments:		
Was this report submitted within 30 business days from 90-day job retention?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If not, please indicate reason(s):		

I hereby certify that the information submitted on this report is true and correct.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

I hereby certify that the information submitted on this report is true and correct.

**Completed By:**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

Phone:

Email: