Clear Form Print

03/2021

SE MILESTONE-2 I/DD, ABI/Autism Supported Employment

MILESTONE/SERVICE DATES: START: _____ **END:** _____

Client Name:	Address:	Phone Number:	Email:

ID M-2 SUPPORTED EMPLOYMENT PLACEMENT REPORT

VR Counselor:			Job Start Date:
Name Of Employer:		Job Title:	
Employer Address:		Job Duties:	
Telephone #:		Supervisor:	
Hourly Wage:	Hours Per Week:	Benefits: ☐ Health Insurance ☐ Paid Sick Leave ☐ Retirement Plan ☐ None ☐ Dental ☐ Paid Vacation ☐ Other	

JOB SEARCH SUPPORTS PROVIDED TO GET A JOB: Total number of hours _____

☐ Weekly Contact	☐ Application Assistance
☐ Interview Skills Training	☐ Personal / Appearance Needs
☐ Job Leads / Information	☐ Problem Solving
☐ Interview Assistance	☐ Worksite Accommodations Developed
☐ Employer Advocacy / Follow-up	☐ We have reviewed possible risks involved in job
☐ Cover Letter/Resume	☐ Employer Contact & Job Development
☐ Transportation Plan & Assistance	☐ Other:
☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	

PROJECTED INTERVENTIONS IN WORK PLACE:

☐ Job Coaching ☐ On Site Hours _____ Per Week ☐ Off Site Hours _____ Per Week	**EMPLOYER INVOLVEMENT** **(CHECK ALL THAT APPLY)** ☐ We may contact employer/supervisor about work performance ☐ Employer is aware of disability ☐ Employer is aware of SE involvement ☐ Employer Contact – _____ (# of times per month)
☐ Client Contact- _____ (times per week) ☐ Face to Face: ☐ Phone, Email, Text:	
☐ Assistance Learning the Job	
☐ Implement Transportation Plan	☐ Personal/Appearance
☐ Problem Solving Skill Training & Support	☐ Other:
☐ Work Related Behaviors	☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)
☐ Attendance Skills	**Comments:**
☐ Implement Worksite Accommodations	

I verify that the information above is correct. I understand that I have a right to revoke this consent in writing if I so desire in the future.

Client Signature _____ Date _____

Authorized Representative Signature _____ Date _____

SE Specialist Signature _____ Date _____

VR Staff Signature _____ Date _____

☐ Copy sent to DD Service Coordinator