SE MILESTONE-5 A&B I/DD, ABI/Autism Employment Report

Check one:

☐ **MS 5A Start/End date (6 months from successful outcome date):** _____

☐ **MS 5B Start/End date (12 months from successful outcome date):** _____

Client Name:	Address:	Phone Number:	Email:

M-5 A/B SUPPORTED/CUSTOMIZED EMPLOYMENT REPORT

DATE FORM SENT:	COMPLETED BY/PHONE #
NAME OF EMPLOYER:	JOB TITLE & DUTIES:
HOURLY WAGE:	CLIENT SATISFACTION / FEEDBACK:
HOURS PER WEEK:	EMPLOYER SATISFACTION / FEEDBACK:

CLIENT LONG TERM SUPPORT PROVIDED (check all that occurred and provide a brief narrative about each in the comments section)

☐ Work Performance Skills	☐ Coping Skills	☐ Natural Supports
☐ Social Skills on the Job	☐ Conflict Resolution	☐ Problem Solving
☐ Job Attendance	☐ Personal Appearance	☐ Worksite Accommodations
☐ Interpersonal Relationships (employer, supervisor, co-workers)		☐ Transportation
☐ Training for Income Reporting/Benefits Monitoring Supports (Social Security, Medicaid, Housing, SNAP)		
☐ Other, list:		

COMMENTS - Provide details on all supports checked above.

Client Signature_____ Date_____

Authorized Representative Signature _____ Date_____

SE Specialist Signature_____ Date_____

VR Staff Signature _____ Date_____

☐ Copy sent to DD Service Coordinator (if applicable)

☐ Copy sent to Authorized Representative (if applicable)