

**SE MILESTONE-4 Behavioral Health**

MILESTONE/SERVICE DATES: START: \_\_\_\_\_ END: \_\_\_\_\_

Client Name:	Address:	Phone Number:	Email:
--------------	----------	---------------	--------

**M-4 TRANSITION TO EXTENDED SERVICES**

VR Counselor:		Possible outcome date:	
IPE Job Goal:		Job Title:	
Name of Employer:		Job Duties:	
Hourly Wage:	Hours per Week:		
<b>MILESTONE 4 CRITERIA:</b> <input type="checkbox"/> Client Satisfaction <input type="checkbox"/> On the Job at least 90 days <input type="checkbox"/> Employer Satisfaction <input type="checkbox"/> Extended Services Plan Ready to be Implemented		<b>Benefits:</b> <input type="checkbox"/> Health Insurance <input type="checkbox"/> Retirement Plan <input type="checkbox"/> Paid Vacation <input type="checkbox"/> Paid Sick Leave <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Dental	
		<b>EMPLOYER FEEDBACK:</b> <input type="checkbox"/> NA—no contact per client request	
		<b>NAME OF CONTACT:</b>	

**SUPPORTED EMPLOYMENT SERVICES PROVIDED**

**EXTENDED SERVICES PLAN**

<input type="checkbox"/> Employment Advocacy <input type="checkbox"/> Job Search Activities <input type="checkbox"/> Job Seeking Skills <input type="checkbox"/> Job Coaching <input type="checkbox"/> On Site <input type="checkbox"/> Off Site <input type="checkbox"/> Client Contact: (Avg # of times per week) ____ <input type="checkbox"/> Face to Face: <input type="checkbox"/> Phone, Email, Text: <input type="checkbox"/> Employer Contact: Face-Face, Calls <input type="checkbox"/> NA <input type="checkbox"/> Work Performance Skills <input type="checkbox"/> Transportation <input type="checkbox"/> Benefits Monitoring (Social Security, Medicaid, housing, food stamps) <input type="checkbox"/> Symptom Management <input type="checkbox"/> Problem Solving <input type="checkbox"/> Work / Life Balance <input type="checkbox"/> Work Related Social Skills	<input type="checkbox"/> Client Contact: (projected number of times per month) __ by: <input type="checkbox"/> Face to Face: <input type="checkbox"/> Phone, Email, Text: <input type="checkbox"/> Liaison support with supervisor/co-workers for advocacy and other communication <input type="checkbox"/> Mental Health support/Symptom management <input type="checkbox"/> Development /maintenance of natural supports <input type="checkbox"/> Monitoring worksite accommodations <input type="checkbox"/> On-going job coaching/skill training for new job tasks <input type="checkbox"/> Transportation/needed revision to transportation plan with schedule changes <input type="checkbox"/> Problem-solving supports <input type="checkbox"/> Benefits Monitoring (Social Security, Medicaid, housing, food stamps) <input type="checkbox"/> Other (Describe) <input type="checkbox"/> Other (Describe)
<b>COMMENTS on Extended Services needs:</b>   	

X _____ Client Signature	_____ Date
X _____ Authorized Representative Signature	_____ Date
X _____ Supported Employment Specialist Signature	_____ Date
X _____ Nebraska VR Specialist Signature	_____ Date