

CONSUMER NAME: _____ VESID ID NUMBER: REPORT MONTH:
Month Year

VENDOR NAME: _____ VENDOR ID NUMBER:

Job Development Contacts (Attach additional pages if needed)

Date of Contact	Employer Name	Name of Person Contacted
Outcome		

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Outcome		

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Outcome		

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Outcome		

CONSUMER NAME: _____ VESID ID NUMBER: REPORT MONTH:
Month Year

VENDOR NAME: _____ VENDOR ID NUMBER:

Worksite Information (Note changes only, attach additional pages if needed)

PLACEMENT DATE <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Month Day Year</i>		EMPLOYER NAME			
DATE LEFT JOB <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Month Day Year</i>		EMPLOYER ADDRESS <i>Street City State Zip Code + Zip4</i>			
CONTACT NAME		CONTACT JOB TITLE		CONTACT PHONE NUMBER () -	
CONSUMER JOB TITLE		DOT CODE (9 digit)	RECEIVES HEALTH INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
HOURLY RATE	HOURS WORKED PER WEEK (If less than 20, see page 5)		IF NOT MAKING COMPETITIVE WAGE, IS WORKING TOWARDS COMPETITIVE WAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No		
JOB DUTIES 					
EMPLOYMENT MODEL (check one)					
<input type="checkbox"/> Individual Placement		<input type="checkbox"/> Enclave		<input type="checkbox"/> Mobile Crew	
		<input type="checkbox"/> Affirmative Business		<input type="checkbox"/> Transitional Employment for Mental Illness	
Employer satisfied with consumer performance? <input type="checkbox"/> Yes <input type="checkbox"/> No Consumer satisfied with employer / employment? <input type="checkbox"/> Yes <input type="checkbox"/> No Include documentation in the consumer file.					

CONSUMER NAME: _____

VESID ID NUMBER:

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REPORT MONTH:

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Month *Year*

VENDOR NAME: _____

VENDOR ID NUMBER:

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WAIVER REQUEST / APPROVAL

Less than 20 Hours – Fewer than 20 hours of employment per week by the time of transition to extended services. Attach additional pages if needed.

Justification/Rationale (required)

To be completed by VESID/CBVH staff only:
Waiver Approved: Yes No If no, enter reason _____
Name _____ Date _____

Off-site Service - Based on consumer needs, twice monthly contact will be conducted off-site. Attach additional pages if needed.

Justification/Rationale (required)

To be completed by VESID/CBVH staff only:
Waiver Approved: Yes No If no, enter reason _____
Name _____ Date _____

On-site intervention required for more than 18 months – More than 18 months of intensive services are needed to achieve the employment outcome once placement in a job occurs (the 18-month maximum is the cumulative total for the life of the current case regardless of the number of job placements). Attach additional pages if needed.

Justification/Rationale (required)

To be completed by VESID/CBVH staff only:
Waiver Approved: Yes No If no, enter reason _____
Name _____ Date _____