

(This report should be completed and sent to DRS Counselor throughout the 90 day follow-up period while the case is in DRS "employed" status until DRS case is closed.)

**ONGOING SUPPORT SERVICES  
REPORT**

**I. Vendor Information**

Vendor #:	
Vendor Name:	
Vendor Address:	
Emp Specialist:	
Emp Spec Phone #:	

**II. Consumer / Billing Data**

Consumer:		<b>Participant ID #</b>	
DRS Case #:		DRS Counselor:	Case Manager:
Vocational Goal:			
<b>LTESS</b> Hours Billed:		Billing Period:	

**III. Employment Data**

**Consumer Job Title:** \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Wage \_\_\_\_\_ Work Schedule: \_\_\_\_\_

(Hourly): \_\_\_\_\_

**# Hrs Worked at time of Placement (Weekly):** \_\_\_\_\_ **# Hrs Worked at Present (Weekly):** \_\_\_\_\_

Immediate Supervisor & Title: \_\_\_\_\_

**Accommodations:** \_\_\_\_\_  
 \_\_\_\_\_

**Transportation Issues:** \_\_\_\_\_  
 \_\_\_\_\_

**Natural Supports:** \_\_\_\_\_  
 \_\_\_\_\_

*A. Employer Rating (attach SE Form 5 to this report on a Quarterly basis).*

*Last Employer Rating*

*Completed:* \_\_\_\_\_

*Next Employer Rating Due:* \_\_\_\_\_

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**IV. Intervention Activities-Pertains to Services While DRS Case is Open in "Employed" Status**  
 Ongoing support services must include, at a minimum, twice-monthly monitoring at the work site of each individual in Supported Employment to assess employment stability, unless under special circumstances, especially at the request of the individual, the individual's program of services provides for off-site monitoring, and based upon that assessment, the coordination or provision of specific services, at or away from the work site, that are needed to maintain employment stability. If off-site monitoring is determined to be appropriate, it must at a minimum consist of two meetings with the individual and one contact with the employer each month. {Federal Register, February 18, 1994 [Vol. 59, no. 34; p. 8343]}.

Initiation Date of Follow-Along Services: \_\_\_\_\_

<i>Date</i>	<i>Contact Made:</i> (list people contacted to include consumer, family, employer, etc.)	<i>Type of Contact</i> (phone, face to face, off-site, on-site, etc.)	<i>Issues/Outcome</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Intervention Summary**

Total Consumer Work Hours: \_\_\_\_\_  
 Total Monthly Intervention Hours: \_\_\_\_\_  
 Average Monthly Intervention %age \_\_\_\_\_

**V. Issues to Monitor** (Narrative should reflect but should not be limited to employment goals and progress, medical issues/barriers, case management, residential, financial and/or other concerns that may affect employment stability.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HOURS BILLED** DIRECT/INDIRECT SERVICES TIME \_\_\_\_\_ Employment Specialist \_\_\_\_\_  
 TRANSPORTATION TIME \_\_\_\_\_ Date \_\_\_\_\_  
 DOCUMENTATION TIME \_\_\_\_\_  
 TOTAL TIME \_\_\_\_\_