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| **Client:** Click here to enter text. | **Date: Click here to enter text.** |
| **Person Completing Report:** Click here to enter text. |  |
| **Effective Date of Transfer to Long Term Care Support and End of DVR Funding of Supported Employment:**  **Click here to enter text.** | |
| **Employer Contact Information:**  Click here to enter text. | |
| **Employment Start Date:**  Click here to enter text. | |
| **Employment Job Title:**  Click here to enter text. | |
| **Name of Supervisor:**  Click here to enter text. | |
| **Wages and availability of benefits.**  Click here to enter text. | |
| **A description of impact on Social Security Benefit eligibility.**  Click here to enter text. | |
| **Detailed description of the supports anticipated to receive outcome payment.**  Click here to enter text. | |
| **Dates/hours and types of support-task behavior, sequencing, work quality/accuracy, speed etc.).**  Click here to enter text. | |