

SUPPORTED EMPLOYMENT SERVICES

I. LEGAL AUTHORITY:

The Rehabilitation Act of 1973, 29 U.S.C. 701, as amended; 29 U.S.C. 711(c); Section 7(34) and 12(c) of the Act; 29 U.S.C. 706(34); 29 U.S.C. 795g-n Title VI Part C, Public Law 99-506, as amended; 34 CFR 77.1, 34 CFR 361.5(b)(20)(33)(38)(53)(54)(56).

II. POLICY STATEMENT AND PURPOSE:

The State Supported Employment Services Program is authorized to assist individuals with the most significant disabilities – Category I (as defined in Section 115.22) for whom competitive employment in an integrated setting would have been unlikely without on-going support and other appropriate services. The Program assists these individuals in acquiring the skills and experience needed to enter or retain competitive employment by organizing and making available services based on a determination of the individual's needs as specified in the Individualized Plan for Employment (IPE) (*ORS-17*). This section will define who qualifies for the services, the services to be provided, time limits of the services, IPE development, and case closure.

III. DEFINITIONS:

A. **Supported Employment** means:

1. Competitive employment, in an integrated setting, for which an individual with the most significant disabilities is compensated at or above the minimum wage, is employed on a full-time or part-time basis in an integrated setting, and has access to on-going support services as needed:
 - a. Integrated setting means a work setting typically found in the community in which an individual with the most significant disabilities interacts with non-disabled individuals, other than non-disabled individuals who are providing services to that individual.
 - b. Most significant disabilities refers to individuals for whom competitive employment has not traditionally occurred or for whom competitive employment has been interrupted or intermittent as a result of a significant disability; and comparable positions interact with other persons.
 - c. And who, because of the nature and severity of their disabilities, need intensive supported employment services and extended services after transition in order to obtain and maintain this work.

2. Transitional employment for individuals with the most significant disabilities means a series of sequential temporary job placements in integrated work settings with on-going support services in order to build work skills and experience until job permanency is achieved.
 3. Post-employment services which may be provided if not available from an extended service provider.
- B. Duration of **Supported Employment Services** means on-going support services provided by the designated State unit
1. For a period not to exceed 18 months, unless under special circumstances a longer period to achieve job stabilization has been jointly agreed to by the individual and the rehabilitation counselor and identified in the IPE, before an individual with the most severe disabilities makes the transition to extended services.
 2. **Extended Services** means on-going support services and other appropriate services provided by a State agency, a private, nonprofit organization, employer, or any other appropriate resource after an individual with the most significant disabilities has concluded support services from State vocational rehabilitation agency support.
- C. **On-going Supported Employment Services** means services that are based on an assessment of employment stability and provision of specific services needed to maintain employment and must include:
1. at least twice monthly monitoring of each individual in supported employment either at the work site or off-site based on client preference, the IPE, and job performance to identify any other service needed in order to ensure employment stability;
 2. Ongoing assessment of rehabilitation needs through the provision of skilled job trainers who accompany the individual for intensive job skill training at the work site; job development and training; social skills training; regular observation or supervision of the individual; follow-up services with employers and others invested in clients employment, in order to reinforce and stabilize the job placement and facilitate development of natural supports at the worksite;
 3. Services based on the determination of the individual's needs, as specified in the IPE and identified through the ongoing support services.

IV. GUIDELINES ON IMPLEMENTATION OF SUPPORTED EMPLOYMENT POLICY:

A. ORS Supported Employment Process (requires additional documentation)

1. Referral/Eligibility Determination

- a. Rehabilitation Counselors will work with referral sources to ensure case is not already active within ORS system.
 - i. When active ORS clients are referred, SE Eligibility is assessed and determined by ORS Rehabilitation Counselor, and identification of Long-Term Support Providers should be made when applicable.
- b. Referral packet from Developmental Disabilities/Mental Health to ORS includes: Application for Services (ORS-4); Releases of Information (ORS-37); Medical/Psychological, SSI/SSDI, and other supporting documentation; Evaluation/Assessment – Individualized Pre-Placement Assessment (IPPA)(ORS-153); Current Health & Functional Capacities Self Assessment Form (ORS-3).
 - i. Upon receipt and review of materials, ORS Rehabilitation Counselor will meet with client.
- c. Information is reviewed by ORS Rehabilitation Counselor and Eligibility for ORS services is determined. If Eligibility and Order of Selection is met, case is “Moved to Status 10”.
 - i. Supported Employment Criteria is met, and the Supported Employment Eligibility Guideline is completed, signed and dated.
- d. If information is insufficient for eligibility determination and/or IPE development, the Rehabilitation Counselor will refer the case back to the referral source.

2. IPE Development

- a. IPE requirements are outlined in Section 115.3, Supported Employment. IPE developed with the client must:

- i. Specify the supported employment services to be provided by ORS.
 - ii. Specify the expected extended services needed, which may include natural supports.
 - iii. Identify the sources of extended services and complete the “Provider Agreement to Provide On-Going Support Services” with the long term funding source (ORS-160) or, to the extent that it is not possible to identify the source of extended services at the time the IPE is developed, include a description of the basis for concluding that there is a reasonable expectation that those sources will become available.
 - iv. Provide for periodic monitoring to ensure that the individual is making satisfactory progress toward meeting the weekly work requirement established in the IPE by the time of transition to extended services.
 - v. Provide for the coordination of services provided under an IPE with services provided under other individualized plans established under other Federal or State programs.
 - vi. Identify that on site training will be provided if job skills training is to be provided.
 - vii. Include placement in an integrated setting for the maximum number of hours possible based on the unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of individuals with the most significant disabilities.
- b. IPE is signed by client and ORS Rehabilitation Counselor and is reviewed and initialed by supervisor. After completion of 1st 2 steps, IPE is signed by counselor. Client receives a copy of the approved IPE after all signatures are in place. Case is moved to Status 19.
 - c. ORS Rehabilitation Counselor authorizes Pre-Employment Planning and processes the bill upon receipt.
 - d. The lack of community resources for supported employment services provision can not be a reason for determining an individual with the most significant disabilities to be ineligible for vocational rehabilitation services. If the individual with the most significant disabilities is determined to be potentially employable through the

provision of supported employment services, s/he must be found eligible for the Vocational Rehabilitation Program even if a key resource(s) needed to provide those services is currently unavailable. In these situations the Vocational Rehabilitation agency has the lead responsibility in the development of resources and agreements for extended services. The ORS Rehabilitation Counselor:

- i. Certifies the individual is eligible for the VR program; and
 - ii. Informs the individual that supported employment services cannot be initiated until an extended resource is obtained; and
 - iii. Seeks out the resource(s) for the needed extended services; and
 - iv. May initiate VR services with a strong likelihood of a source of extended services, including natural supports. The IPE must include a statement describing the basis for the conclusion that such resources will be available.
3. SE/Job Development/Placement
- a. ORS Rehabilitation Counselor authorizes Job Placement
 - i. In cases where the client is entering into training prior to job seeking, the authorization for Job Placement is put on hold pending the completion of the training.
 - b. When Job Placement occurs, vendor provides the following information: employer, job title, hours, duties, benefits. Case is moved to Status 22.
 - c. After 30 days of employment, vendor submits SE On-site Work Evaluation Report (ORS-152) and Job Development/Placement bill to ORS.
4. SE Job Retention Services
- a. ORS Rehabilitation Counselor processes bill for payment of Job Placement and authorizes SE Job Retention services.
 - b. Long-Term Supports needed and identified on SE On-Site Work Evaluation will be provided to keep individual employed. Opportunities for advancement are identified. SE Job Retention Monthly Reporting Forms (ORS-157) are submitted for 2nd and 3rd month reflecting program's long-term support plan.

5. Individual is considered successfully employed 90 days from job start date.
6. Vendor submits bill with the 2nd SE Job Retention Monthly Report Form (ORS-157) and payment is processed based on number of hours client is working. (Refer to Services and Vendor Codes and Fee Schedule).
7. Employment is stabilized and Case is closed 26.

V. Applicable Forms

1. Individualized Plan for Employment (IPE) (ORS-17)
2. Release of Information (ORS-37)
3. Current Health & Functional Capacities Self Assessment (ORS-3)
4. Eligibility and Order of Selection Checklist (ORS-154)
5. Supported Employment Guideline (ORS-SEGuide)
6. Provider Agreement to Provide Ongoing Support Services (ORS-160)
7. Individual SE Pre-Placement Assessment (ORS-153)
8. SE On-Site Work Evaluation Report (ORS-152)
9. SE Retention Monthly Reporting Form (ORS-157)



DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES

“Helping individuals with disabilities to choose, find and keep employment”

***A GUIDE TO ASSIST YOU TO DEVELOP YOUR
INDIVIDUALIZED PLAN FOR EMPLOYMENT [IPE]***

(Use with ORS Form 17)

What Is The Purpose Of An Employment Plan [IPE]? Your employment plan [IPE] identifies your job goal and shows how to get there. It may be changed when necessary, but both you and your Qualified Vocational Rehabilitation Counselor must agree with the changes.

Where Do You Begin? Choosing your employment goal is the most important step you will take to succeed in the job. There are many ways to help you decide. You begin by learning about yourself, including your strengths, skills, abilities, values and interests, as well as your barriers to employment. Next you learn about jobs. These steps will help you make an informed choice about your employment goal. Your counselor will assist you with this process. If you don't understand any step in this process, **ask questions.**

What Are The Steps To Reach Your Employment Goal Based on Informed Choice and A Current Assessment Of Your Strengths and Needs?

- Choose the necessary services to reach your employment goal.
Examples include: Assessment, Counseling & Guidance, Job Preparation, Training, Work Experiences in Integrated Settings, Assistive Technology Services and Devices, and other services that assist you to prepare for and keep employment.
- Some services in your Plan may require a financial needs test and your participation in payment.
- Learn about work incentives and analyze how working will affect your benefits (e.g. SSI/SSDI/FIP/Housing Subsidy).
- Plan your transportation needs to and from work.
- Develop your job seeking skills as early as possible (e.g. active job search techniques, resume writing, interviewing, and identifying reasonable accommodations need).
- Plan for on-going support services (e.g. long-term job supports, personal care assistance, etc.) you may need after becoming employed, and determine how they will be paid for.

The steps to reach your employment goal should be based on informed choices, Vocational Rehabilitation policies, and reasonable costs. If you are a high school student, your employment plan may build upon the goals in your IEP. If you are an individual needing on-going supports from another agency to maintain employment, your employment plan may identify how you can get these services.

(Continued on Reverse Side)

What Information Is Needed?

<i>Employment Goal:</i>	What your goal is based on informed choice and when you expect to reach that goal.
<i>Objective(s):</i>	What needs to be done.
<i>Service(s):</i>	How it will be done.
<i>Provider(s):</i>	Who will do what.
<i>Service Outcome(s):</i>	How successful service outcomes will be measured.
<i>Time Frame(s):</i>	When your services will start and be completed.
<i>Funding Source(s):</i>	How will your services be paid for (e.g. VR and/or other sources).

As a Partner in Your Plan, Your VR Counselor Will:

- Assist you to understand the planning process.
- Help you select services and providers.
- Provide you in writing with informed choice options.
- Provide you with an approved, signed copy of your Plan.
- Help you review your Plan periodically (at least once a year) and amend if needed.

As a Partner in Your Plan, You Will Need To:

- Work steadily to your goal and carry out your responsibilities identified in the Plan.
- Maintain an open line of communication with your VR counselor.
- Evaluate your progress toward your goal and solve problems when they come up.
- Share in the costs of services when your income and resources are above VR guidelines.
- Apply for and use other benefits to pay for specific services.
- Report your success when you have reached your career goal (obtained employment), and provide ORS with information about your job, pay, benefits and hours.

Your Rights as a Customer of ORS:

- Privacy: No information about you can be shared with anyone outside of ORS without your written permission.
- Fairness: ORS will not discriminate against you because of gender, race, national origin, age, disability, religion or sexual orientation.
- Informed Choice: You have the right to make informed choices regarding your goals and services based on YOUR abilities, strengths, skills, values and interests.
- Future Services: ORS will help you after you have reached your employment goal when you need additional services to continue working or regain employment.
- Problem Resolution: ORS will help you with any steps in problem resolution. If you disagree with a VR decision, you are encouraged to talk to a VR Supervisor, Deputy Administrator, or ORS Administrator. You can request mediation or a formal hearing with an Impartial Hearing Officer in the Department of Human Services. You can also seek help from the Client Assistance Program at the RI Disability Law Center, 275 Westminster Street, Suite 401, Providence, RI 02903. Phone: 831-3150 (v); 831-5335 (tty); and toll free (800) 733-5332.



DEPARTMENT OF HUMAN SERVICES – OFFICE OF REHABILITATION SERVICES

40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ (401) 421-7016 (TTY)

“Helping individuals with disabilities to choose, find and keep employment”

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. (Name of Client)

My Date of Birth: ____ / ____ / ____

My Social Security Number: ____ - ____ - ____

II. My information is to be disclosed to:

And is to be disclosed by:

Office of Rehabilitation Services

Maximus

40 Fountain Street

PO Box 25105

Providence, RI 02903

Alexandria, VA 22313

III. The purpose or need for this release of information is:

To obtain the information checked below that will assist me in vocational rehabilitation planning

My own personal and private reasons

Other (specify): Ticket In-Use SVR

IV. The information to be disclosed from my health record: (check all of the boxes that apply)

Vocational Medical Educational Social

Financial Psychiatric/Psychological Other (specify): _____

Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)

Specific Information Needed: Ticket Status, SSA Benefit Status, Work Status, & Salary IPE/WP

Dates of Service: _____ to _____

I would also like the following sensitive information disclosed: (check the applicable box(es))

Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment

Sexually Transmitted Diseases

V. I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me.

Enter if different from one year after the date below)

Signature of Client

Date

Signature of Authorized Representative

Relationship to the Client

Date

Instructions for Completing Form ORS-37

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.
2. Section I – print name of the client whose information is to be released.
3. Section II – print the name and address of the person or organization authorized to release and/or receive the information. Also, provide the name of the DHS/ORS representative, unit and address that will receive and/or release the information.
4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)
5. Section IV – check all of the boxes that apply.
 - a. Vocational, Medical, Educational, Social, Financial, Psychiatric/Psychological
 - b. Other (*specify*) – specific information identified by the client (e.g., billing, employee health)
 - c. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
 - g. Specific Information Needed – clearly identify the precise information to be disclosed.
 - h. Dates of Service – note the first and last date of service requested.
 - i. RELEASE OF SENSITIVE INFORMATION – check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases – patient must check the appropriate box!
6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.
7. Section V – Authorized Representative (e.g., parent, legal guardian, power of attorney)
8. A copy of the completed Form ORS-37 will be given to the client.



INDIVIDUALIZED PLAN FOR EMPLOYMENT [IPE]

Name: _____ **Date:** _____ **SSN:** _____

Plan Type: This is my first Employment Plan This is a change in my Plan dated _____

My Career or Job Goal: _____

My counselor and I think I will reach my goal by _____.

We think I will need ORS services after I become employed: Yes or No

To reach my goal, I will complete the activities listed below:

OBJECTIVE: What needs to be done?	SERVICE: How will it be done? Name services.	PROVIDERS: Name provider/vendor.	SERVICE OUTCOME: How successful outcome will be measured.	TIME FRAME: Service Begins/Service Ends	FUNDING SOURCE:

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SUPPORTED EMPLOYMENT (To be completed ONLY if supported employment is part of your plan)

I will keep my job with help from: on-site job supports/coach from _____

off-site job supports/coach from _____ natural support from co-workers or _____

Is there a signed “Agreement to Provide On-Going Support” (Extended Services), after the “time-limited supports” through VR are completed? Yes No If no, I believe I will have help from the following Extended Services Resource _____

because (state reasons) _____.

I expect my transfer to the above resource by (date) _____.

My Comments on my Employment Plan: _____

Signatures: _____

Individual/Representative

Date

ORS Representative Approval

Date

Periodic Reviews (Details Provided in Case Narrative Entries)

Date	Outcome	Counselor Initials

Case Closure Amendment, Not Rehabilitated Because of Ineligibility

Basis for Determination of Ineligibility (check one):

- Individual no longer has a barrier to employment, or
- Individual does not need VR services, or
- Individual cannot benefit in terms of an employment outcome from VR services.

Involvement and Views of Individual in Such Decision:

Discussed with client the option of assigning his/her Ticket to Work with an EN after ORS closure to maintain moratorium on CDR and to have ongoing support services with new EN. Sent client TTW closure letter and advised TTW coordinator of closure date.

Case Closure Amendment, Rehabilitated

Basis for Determination of Rehabilitation (check all):

- Substantial services, including guidance and counseling, contributed to the employment outcome, and
- The outcome is consistent with the individual's strengths, priorities, interests, capabilities, abilities, and informed choice, and
- The employment outcome is in the most integrated setting consistent with informed choice, and
- Employment has been maintained at least ninety (90) days, and
- Employment is remunerated at or above minimum wage, is commensurate with the pay and benefits received by non-disabled colleagues, or is in accordance with the Fair Labor Standards Act and,
- The employment appears satisfactory to the employer and the individual

Closure Entries Completed By: Signature _____ Date _____



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“Helping individuals with disabilities to choose, find and keep employment”

**CURRENT HEALTH AND FUNCTIONAL CAPACITIES
SELF-ASSESSMENT**

Name: _____ Date: _____

Height: _____ Weight: _____ D.O.B.: _____ SS#: _____

Please list the most important problem(s) that interfere with your working: _____

For each area below, choose whether you have EXCELLENT or AVERAGE health or ability in that area or whether you have some problems. This is important information in planning for work.

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
HEARING				
SEEING				
SPEAKING				
SITTING				
STANDING				
WALKING				
KNEELING				
BENDING				
LIFTING				
PUSHING/PULLING				
HANDLING/FINGERING/FEELING				
CLIMBING				
BALANCING				
COORDINATION				
STRENGTH				
ENERGY/STAMINA				
BREATHING				
ALLERGIES				
REMEMBERING				
LEARNING				
READING				
WRITING				
CONCENTRATING				

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
MAKING DECISIONS				
SOLVING PROBLEMS				
GETTING ORGANIZED				
COLD/HOT WEATHER				
GROOMING/SELF CARE				
PEOPLE (GETTING ALONG WITH OTHERS)				
NERVOUSNESS/ANXIETY				
DEPRESSION				
MEALS/DIGESTION				
TAKING MEDICATIONS				
USING TRANSPORTATION				
USING ADAPTIVE EQUIPMENT				
JOB SKILLS				
HOW TO FIND AND GET JOBS				
WORK HABITS				
BEING RELIABLE/DEPENDABLE				
WORK RECORD				
OTHER (PLEASE LIST				

How often have you been hospitalized in the last two years? _____

Do you use? () Tobacco () Alcohol () Other Drugs If yes, how much? _____

Do you have a history of dependency on () Drugs () Alcohol

If so, what is the date of your sobriety? _____

In planning for work, how concerned are you about loss of SSI/SSDI benefits? _____

This is the best estimate of my abilities and limitations.

Signature



**RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES**

“Helping individuals with disabilities to choose, find and keep employment”

ELIGIBILITY/ORDER OF SELECTION CHECKLIST

NAME: _____ SS #: _____

DISABILITY: _____ SECONDARY DISABILITY: _____

VERIFIED BY: __ MEDICAL/SCHOOL RECORDS __ APPLICANT’S STATEMENTS __ COUNSELOR OBSERVATIONS

	LIMITATION?	YES	NO	YES?	IMPEDIMENT TO EMPLOYMENT
MOBILITY	Drive				Needs adaptation or training to drive, unable to drive
					Cannot travel in unfamiliar places alone
					Need modified vehicle to travel
	Use Bus				Unable to use public transportation independently
	Walk				Needs adaptive equipment for ambulation
					Unable to walk 100 yards w/o pausing to rest
	Climb				Unable to climb a flight of stairs
Other					
COMMUNICATION	Hearing				Cannot hear or understand meaning of ordinary spoken conversation
					Needs specialized equipment/interpreter to communicate
	Speaking				Speech is unintelligible, difficult to understand
					Talks excessively, interrupts, intrudes inappropriately
					Needs specialized equipment/interpreter to communicate
	Reading				Cannot read manuals, messages, rules, safety signs
	Writing				Cannot take messages, notes
Other					
INTER PERSONAL	Depression Anxiety				Social isolation/withdrawal/rejection, sudden shifts in mood and attitudes, low frustration tolerance, difficulty accepting supervisory monitoring or criticism
	Getting Along With Others				Poor peer relationships/interactions, poor eye contact. fails to understand obvious cues, unable to work with others in a team, unable to deal with conflict
	Other				
SELF CARE	Prepare Meals				Unable to cook, shop, plan menu
	Pay Bills				Unable to pay rent, utilities, etc., trouble handling money
	Grooming				Needs assistance with personal grooming, poor hygiene
	Taking Medications				Needs assistance administering medication, forgetting to take prescribed medication may lead to job problems
	Resources				Cannot contact resources for assistance when problems arise, not aware of available resources
	Other				

	LIMITATION?	YES	NO	YES?	IMPEDIMENT TO EMPLOYMENT
SELF-DIRECTION	Impulsive				Places self at risk of accident by not thinking before acting, unable to work alone
	Solving Problems				Does not show initiative, frequently needs to be told what to do on the job
	Organization				Cannot devise plan to achieve goals, work site is disorganized
	Other				
WRK SKILLS	Job Skills				Cannot use previous skills because of disability, no job skills developed, slow work rate, requires additional time to learn new tasks, difficulty accepting direction from supervisor
	Work Habits				Poor attendance, often late, does not call in, disability causes person to lose time from work, poor concentration
	Work Record				Poor references, frequent job changes, long-term unemployment, no work history
	Organized				Needs help with organization, work area is disorganized
	Other				
WORK TOLERANCE	Sitting				Cannot sit for long periods
	Standing				Cannot stand for extended period of time
	Bending				Cannot bend to pick up work products from lower level
	Lifting				Cannot lift over ____ pounds
	Push/Pull				Cannot push or pull objects
	Handling, Fingering				Cannot do work requiring extensive fine finger dexterity, cannot successfully work on an assembly line
	Balance				Poor balance poses a risk in some environments
	Coordination				Poor motor coordination, clumsiness, eye-hand-foot movements are slower than average
	Energy/Stamina				Tires easily, cannot sustain a full work day
	Breathing/Allergies				Difficulty with exertion, cannot be exposed to dust/air pollutants/chemicals/fumes
	Vision				Difficulty perceiving differences in shapes and sizes in objects or graphic material. Inability to perceive pertinent detail with words and numbers and observe differences
	Other				

This is my best estimate of my abilities and limitations _____
Signature (Required)

Eligibility: Individual has a ___ **SEVERE** ___ **NON SEVERE** disability which results in significant functional limitations in ___ areas. Individual requires VR Services for employment. This individual is classified as a **Category** ___ in the **Order of Selection**. Services required are expected to include: _____

Counselor Signature Date



**RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES**

“Helping individuals with disabilities to choose, find and keep employment”

ELIGIBILITY

To be eligible for Vocational Rehabilitation services, every individual must meet the following criteria:

1. the individual must have a physical or mental impairment
 2. which causes a substantial barrier to employment, and
 3. the individual must be able to benefit from vocational rehabilitation services (this is usually presumed), and
 4. need vocational rehabilitation services in order to achieve employment.
-

ORDER OF SELECTION

Whenever the state Vocational Rehabilitation agency does not have enough resources to help everyone who is eligible for services, a priority system must be used. This system is called an **Order of Selection**. In Rhode Island, there are three (3) priority categories.

The three (3) priority categories are defined by the severity of an individual’s disability, including how many life areas are limited as a result of the disability. There are seven (7) life areas which may be limited by a disability: **mobility, communication interpersonal skills, self-care, self-direction, work skills and work tolerance.**

CATEGORY SELECTIONS

1. Individuals with the **most significant disabilities** – three (3) or more life areas are affected by the disability and multiple services are needed for an extended period of time in order for the individual to work.

WAIT LIST:

2. Individuals with **significant disabilities** – one (1) life area is seriously affected by the disability and multiple services are needed for an extended period of time (***at least 6 months***) in order for the individual to work;
3. All other individuals with disabilities.



**DEPARTMENT OF HUMAN SERVICES
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“Helping individuals with disabilities to choose, find and keep employment”

Supported Employment Guideline

Customer: _____

Meets the following criteria of eligibility for the Supported Employment Services Program:

- Eligible for ORS services under Title I and meets the criteria for Category I under the Order of Selection.
- Competitive employment has not occurred, or has been interrupted or intermittent as a result of these handicaps; and
- Determined by an evaluation of rehabilitation potential to have –
 1. The ability or potential to engage in a training program leading to supported employment;
 2. A need for on-going support services in order to perform competitive work; and
 3. The ability to work in a supported employment setting.

Counselor Signature

Date

SEGuide
Revised 2/10



**DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TTY)**

“Helping individuals with disabilities to choose, find and keep employment”

***Provider Agreement to
Provide On-Going Support Services***

_____ enters into an agreement to provide the On-Going Support Services
(Provider)
for _____, under his/her Individualized Plan for Employment (IPE) with the Office
(Client) of Rehabilitation Services.

The On-Going Support Services will be individualized and clearly defined to assist the above-named to maintain competitive community integrated employment.

It is understood that the Office of Rehabilitation Services will purchase the intensive time-limited on-going support services through fee for service and that the provider will continue with the extended on-going support provision or monitoring of the extended on-going support provision once the need for intensive services according to the IPE is completed.

It is understood that at a minimum the extended on-going support provision is two contacts with the individual employee per month, at the work site unless the IPE specifies that support provision will take place off site, and that individual requirements as stated on the IPE may include more support services than the minimum requirements.

It is understood that Extended Service Agreements may be monitored by the Office of Rehabilitation Services as part of program evaluation once the case is closed with the state agency.

(Provider Signature) (Date)

Copy given to Provider

(Counselor Signature) (Date)

Copy given to Customer



**DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903
(401) 421-7005 (V) ~ (401) 421-7016 (TDD)
www.ors.ri.gov**

**INDIVIDUAL SUPPORTED EMPLOYMENT PREPLACEMENT ASSESSMENT
(Attach Narrative to describe activities)**

Dates of Reporting Period: From: _____ To: _____

Client Name: _____ SS#: _____

Individual's Name/Title providing information: _____

* * * * *

Job Goal/Match: _____ GOE Code: _____

Stated Interests: _____

VOCATIONAL INFORMATION OBTAINED TO DETERMINE JOB MATCH

Vocational Evaluation _____

Educational & Learning Assessment provided by _____

Other (Rehabilitation technology, social & family information): _____

Identification of Extended Support Provider(s): _____

* * * * *

CURRENT ASSESSMENT ACTIVITIES

a. Situational Assessment(s) o Yes o No

Place _____

Job Tryouts _____

Time _____

CURRENT ASSESSMENT ACTIVITIES (continued)

- b. Job Analysis o Yes o No
- c. Labor Market Evaluation o Yes o No
- d. Vocational/Career Counseling o Yes o No
- e. Rehabilitation Technology Evaluation o Yes o No
- f. Benefit Analysis o Yes o No
- g. Job Development o Yes o No

CLIENT VOCATIONAL PROFILE

	ASSETS	LIMITATIONS
<u>Performance</u>		
<u>Behavioral</u>		
<u>Interpersonal</u>		

CLIENTS STYLE OF LEARNING JOB TASKS

JOB FUNCTIONING CONCERNS/POTENTIAL ON-GOING SUPPORT REQUIREMENTS
 (Supervisory, behavioral, tolerance, learning, independence, interpersonal, etc.)

Placed at: _____

Job Title: _____

Hours of work: _____

Pay: \$ _____

Please describe further Job Development required (include type(s) of jobs considered):

Further Assessment required (please describe):

Narrative of Placement Assessment:

Agency Representative/Title

Signature

Date

Agency

Client Signature

Date



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**SUPPORTED EMPLOYMENT ON-SITE WORK EVALUATION
(ATTACH NARRATIVE OF ACTIVITIES)**

I. IDENTIFICATION DATA

Name of Client _____

Place of Employment _____

Hours per week: _____ Pay per hour: _____

Planned hourly work goal: _____

Extended on-going support will be provided by: _____

Dates of Evaluation _____

II. SUPPORTED EMPLOYMENT WORK EVALUATION

Essential Job Tasks: _____

Discrepancies: _____

Production Demands: _____

Discrepancies: _____

Interpersonal Requirements: _____

Discrepancies: _____

II. SUPPORTED EMPLOYMENT WORK EVALUATION (continued)

Other requirements to maintain job, including off-site supports: _____

Discrepancies: _____

III. ATTACH NARRATIVE WHICH INCLUDES INFORMATION ABOUT SPECIFIC SUPPORT REQUIREMENTS:

1. Specify the hourly work goal to be achieved.
2. Specify the anticipated time period for Intensive Support provision.
3. Specify client's support requirements on-the-job and off-the-job.
4. Specify how many hours are required to support the employee in the job.
5. Specify the monitoring plan with the employer and employee if supports are primarily provided off-the-job.
6. Specify the planned fading strategies.

Signature

Title

Agency

Date



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“Helping individuals with disabilities to choose, find and keep employment”

Supported Employment Retention Monthly Reporting Form

Employee Name:			Job Title:		
	<i>(Last)</i>	<i>(First)</i>	<i>(MI)</i>		
Name of Employer:				Month of Report:	
Attendance: Hours worked per Week.				Salary:	
Criteria	Superior	Good	Average	Poor	Comments
Acceptance of Responsibility. <i>(Follows directions, understands work tasks, keeps on the job without close supervision)</i>					
Displays Initiative. <i>(Starts work without being reminded)</i>					
Relationship with Other Employees. <i>(Tactful, courteous, friendly, cooperative)</i>					
Completes Work Accurately. <i>(Thorough and efficient with assigned tasks)</i>					
Adheres to Work Schedule. <i>(Complies with schedules work hours, breaks)</i>					
Displays Good Personal Traits. <i>(Ability to take criticism, positive attitude, flexible)</i>					
Skills Being Developed:					
Career Advancement					
Describe potential opportunities employee has for job promotion:					
Describe supports person will need for job advancement:					
Long Term Supports Necessary:					

Signed: _____

Employment Counselor

Date: _____

Signed: _____

Employee

Date: _____