Extended Services Report

Individual's Name: _____

Contractor: _____ DRS Counselor: _____

Service Begin Date: _____ Service End Date: _____

Current Month of Service: _____

Employer (Business Name): _____

Employer's Address: _____
Street Address *City* *State* *Zip Code*

Employer Contact: _____ Phone Number: _____
First and Last Name

Individual's Job Title: _____ Start Date: _____

Starting Hourly Wage: _____ Current Hourly Wage: _____ Total hours per week: _____

Benefits Available: ☐ Full/Partial Health Insurance ☐ Sick Leave ☐ Vacation ☐ Pension Plan
☐ Other: _____

(Complete using on-site observations, individual's reports, off-site contacts, employer contacts, team meeting discussion, etc.)

Please summarize EC observations of the individual's current performance and support level.

Please provide information as communicated by the employer regarding the individual's current job performance toward achieving a successful employment outcome. Describe steps taken to address any issues identified by the employer or individual that may affect long-term job success.

Please describe any additional extended services identified (i.e. DDS, natural supports, etc.), and explain how the individual will transition to the new source of extended services.

EC Name: _____ Date: _____