Employment Outcome Report

Clear Form

Individual's Name: _____ Case Number: _____

Address: _____ _____ ____ _____
Street Address *City* *State* *Zip Code*

Home Phone Number: _____ Cell Phone Number: _____
Include Area Code *Include Area Code*

Contract: ☐ CE ☐ ER ☐ JP ☐ SE

Vocational Goal on the IPE: _____ Is job related to IPE goal? ☐ Yes ☐ No

Employer (Business Name): _____

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

Employer Contact: _____ Phone Number: _____
First, Last Name, Title *(Area Code) Number, Extension if applicable.*

Individual's Job Title: _____ Start Date: _____

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

SE weekly work goal from IPE: _____ Is the weekly work goal met or exceeded? ☐ Yes ☐ No

Benefits Available: ☐ Full/Partial Health Insurance ☐ Sick Leave ☐ Vacation ☐ Retirement

☐ Other:

List any changes in job duties or responsibilities since employment began:

Document any positive feedback or concerns identified by the individual or guardian. Describe how concerns were addressed:

Document any positive feedback or concerns of the employer regarding the individual's current job performance and describe steps taken to address any concerns identified:

Select "Yes" "No" or "N/A" in response to each statement below:

☐ **Yes** ☐ **No** Was this an Internship, which led to permanent employment?

☐ **Yes** ☐ **No** ☐ N/A For cases involving ongoing/extended support services, the individual has been approved for those services through Developmental Disability Services (DDS). If no, what extended services will be provided and who will pay for them?

EC Name: _____ Date: _____