**Employment & Retention**

**Day 45 Report  Day 90 Report**

**(Please check the appropriate box)**

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| **Consumer Name**: Click here to enter text. | | **Consumer’s Birthdate:** Click here to enter text. |
| **OVR Counselor:** Click here to enter text. | | **SOC #:**  Click here to enter text. |
| **Has the consumer’s contact information changed? Yes  No** | | |
| *If yes, please provide new address:* Click here to enter text. | | |
| *New e-mail:* Click here to enter text. | | *New phone #:* Click here to enter text. |
| **Employer:** Click here to enter text. | | **Supervisor:**  Click here to enter text. |
| **Job Title:** Click here to enter text. | | **Start Date:** Click here to enter text. |
| **Hourly Wage:** Click here to enter text. | **Days/Hours Worked Per Week:**  Click here to enter text. | |
| **Summary:**  Click here to enter text. | | |
| **Benefits (to be completed for 90 Report):** | | |
| Is consumer receiving employer paid medical benefits (at least 51% paid)?  Yes  No   * If yes, started when? Click here to enter text. * Cost to you Click here to enter text.   If no, is it available to you? Click here to enter text. | | |
| Is consumer receiving Social Security benefits?  Yes  No  If yes, what is the adjusted monthly amount? Click here to enter text. | | |
| Please check the appropriate box if consumer is receiving any of the following.  Dental  Vision  Paid Vacation/Sick Leave  SGA | | |
| Please provide information on other benefits not listed above: Click here to enter text. | | |

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| **Case Closed by Provider: Yes  No** |
| If yes, state reason: Click here to enter text. |

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| Signature of ES: |  |
| Please Print Name of ES: | Click here to enter text. |
| Provider Name: | Click here to enter text. |
| Date: | Click here to enter text. |