Kentucky Office of Vocational Rehabilitation

OVR SE 6-Extended Services Plan

Instructions

The purpose of this plan is to provide the counselor with detailed information supporting the transition to extended services. This form requires a signature by the employment specialist and the counselor. The plan is not in effect without both signatures.

Basic Information

Please choose if this is an authorization for Day 1, Day 45, or Day 90. (Choose one)

Select which item the authorization is for.

If this person will receive extended services funding by a Medicaid waiver, this plan needs to be developed by the individual's team.

All Extended Services Plans must be submitted upon completion, reviewed, approved, and signed by the OVR Counselor.

Provider Name

Enter the name of the Community Rehabilitation Provider (CRP).

Name of Consumer

Enter the name of the consumer.

Employer

Enter the name of the consumer's employer.

Job Title or Function

Enter the title of the consumer's job or what they do at the job.

Wage per hour

Enter how much the consumer makes per hour.

Average hours per week

Enter the average number of hours per week that the consumer works.

The consumer is 24 years old or younger (Choose one)	Select yes or no whether the consumer is 24 years old or younger.

Questions related to Extended Services

Answer the questions with as much detail as you can obtain. Be as specific as you can with your answers.

Frequency and Description of On-Site Extended Services-What if anything, do you do with or for the employee regarding job tasks? (For example, is job coaching still being provided? If so, provide details.) How have you shifted these tasks to the employee and/or natural supports? How often, and in what way, will you follow-up with employee and employer?	Please answer each question and provide as much detail as possible.
Frequency and Description of Off-Site Extended Services-Provide the name, title/role, frequency, and detailed description of the type of support being provided. For example: transportation assistance at home, medication management, benefits analysis, SSA reporting, therapies, offsite follow-up by the Employment Specialist.	Please provide the information with as much detail as possible.

Description of Natural Supports on the job-Provide the name, title/role, frequency, and detailed description of the type of support being provided.	Please provide the information with as much detail as possible.
Other Important Information-Anything else that may be needed to support the employee, for example: safety concerns, criminal history expungement, special medication considerations, etc.	Please provide the information with as much detail as possible.
Consumer's Future Employment Goals-These should be person-centered and will change over time. Examples include developing relationships at work, increasing efficiency, taking on new tasks, increasing hours, career advancement, etc. (What strategies have you used, and will you continue to use to address the examples listed?)	Please provide the information and answer the questions with as much detail as possible.

How was input obtained for this plan? (Provide detailed information pertaining to those involved. This should include any information provided by others and how it was used in the completion of this plan.) Name of role of those involved-employee, employment specialists, guardian, other support people, team members, etc.	Please provide the information and answer the questions with as much detail as possible.
Number of hours requested for extended services over the next 45 days	Enter the number of hours you expect to utilize while providing extended services over the next 45 days.
Justification of hours requested	Give the justification for the hours you are requesting.
Employment Specialist Signature	Please sign the plan as the employment specialist.
Employment Specialist Signature Date	Select the month, day, and year of the employment specialist signature or manually enter the date of the of employment specialist's signature using the MM/DD/YYYY format. Please date the form after signing it.

OVR Use Only-Counselor Review

Verified that the employment is Consistent with the individual's strengths, abilities, interests, and informed choice, and stable employment in a competitive integrated setting has been achieved? (Choose one)	After reviewing the Extended Services plan, select yes or no to indicate that you have verified and agree to the information provided. .
Verified that supported employment services documentation has been provided by the CRP and support the transition to extended services? (Choose one)	Select yes or no to indicate that you have verified that all information has been provided and supports the transition to Extended Services. If no, then additional information is to be requested from the CRP. .
Reviewed and approve the Extended Services Plan? (Choose one)	Select yes if the counselor has reviewed and approved the plan. Select no if you do not approve this plan and the transition to Extended Services. .
Expected Start Date for Extended Services	Select the month, day and year for the start date for extended services or enter the start date for extended services using the MM/DD/YYYY format.
OVR Counselor Signature	The counselor needs to sign the form.

OVR Counselor Date

Select the month, day, and year of the date of the counselor signature or manually enter the date of the counselor signature. This is the date the counselor is approving for Extended Services to begin.