**Employment & Retention**

**Day 1 Report**

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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. | |
| **Job Description**: Click here to enter text. | | |
| **Benefits:** | | |
| Please check the benefits that will apply:  Medical  Dental  Vision  Paid Vacation/Sick Leave | | |
| Please provide information on other benefits not listed above: Click here to enter text. | | |
| **Other Important Information To Know**: *State here any information that the OVR Counselor would need to know to further assist the employee with this job.* 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. |