

**GENERAL INFORMATION:**

This Excel file consists of 2 worksheets. Each worksheet is labeled as to its function.

If you are unable to see the tab for the worksheet across the bottom of the screen, click on the maximize button (the center button) located in the upper right-hand corner of the worksheet.

The worksheet is protected to prevent the changing of formulas and formatting features built into the spreadsheets.

You may submit completed forms in an electronic format or printed format. You must ensure that consumer information is protected as required by State and Federal law.

**FOR ELECTRONIC FORMATS ONLY:** If you submit this form to the regional center electronically, use the following naming standard: Each file must start with the designation of "A" followed by the provider's three digit numerical designation and the month and year. See chart for month designations. For example: A372-JA04 is Form DS 1961 SEP for provider ID# 372 for January 2004.

**FOR ELECTRONIC FORMATS ONLY:** This form contains information protected under the Health Insurance Portability and Accountability Act (45 C.F.R. Parts 160, 162 and 164). **The file must be password protected** to ensure the safety of the consumer's information. Coordinate with the regional center regarding protecting the consumer information contained in this form.

**PROVIDER INSTRUCTIONS:***Provider Information*

Check whether the report is the **Initial**, **Annual** or a **Semi-Annual** report.

*Date:* Enter the date of the report in this format mm/dd/yy.

*Provider Name:* Enter the name of the agency as vendored by the regional center.

*Provider Number:* Enter the agency's number provided by the vendoring regional center.

*Address/City/ZIP:* Enter the provider's business street address, city, and ZIP code. The business address should be the address the provider uses to conduct all its business activities. If the provider's business address is outside of California, list the two letter state abbreviation in the city field.

*Phone:* Enter the telephone number of the provider. Enter telephone number as XXX XXX-XXXX.

*Supported Employment Program Consumer Information*

*Last Name:* Enter the consumer's last name.

*First Name:* Enter the consumer's first name.

*UCI:* Enter the consumer's seven digit UCI #.

*IHSP Participants:* Indicate the names of the individuals who participated in the IHSP meeting.

*Supported Employment Program Objectives and Report on Consumer Progress*

*Work Objective #:* Enter the work objective number and objective title

*First Six Month Period:* Enter an "x" in the appropriate box during the first six month period whether the consumer met, partially met or did not meet his/her progression goals.

*Comments/Summary of Achievements:* Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

*Second Six Month Period:* Enter an "x" in the appropriate box during the second six month period whether the consumer met, partially met or did not meet his/her progression goals.

*Comments/Summary of Achievements:* Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

*Behavior or Other Work-Related:* Enter an "x" in the appropriate box if the objective is based on the consumer's behavior or other work-related issues.

*Measurement:* State what method the vendor will utilize to determine the consumer's progress.

*Goal:* State the goal of the objective.

*Services for Objective:* State the services that will be provided to meet the objective's goal.

*Person Responsible:* Provide the name(s) of the staff responsible for the objective services.

*Current Functioning:* State the consumer's current skill level related to the objective.

#### **SUPPORTED EMPLOYMENT PROGRAM - GROUP SERVICES INFORMATION**

*Attendance %:* Enter the attendance average for the last six months.

*Hourly Income:* Enter the average hourly income for last six months.

*Wages per Month:* Enter the average wage for the last six months,

#### **SUPPORTED EMPLOYMENT PROGRAM - INDIVIDUAL PLACEMENT INFORMATION**

*Intervention %:* Enter the average percent of time the consumer required intervention for the last six months.

*Hours worked per month:* Enter the average monthly hours worked for the last six months

*Wages per Hour:* Enter the average monthly wages for the last six months,

#### **NOTICE**

Read the notice and use the information to safeguard the consumer's information in accordance with the Health Insurance Portability and Accountability Act (45 C.F.R. Parts 160, 162 and 164).

**Continuation sheet** (Additional Objectives Progress: Complete an additional worksheet for each objective as necessary.)

#### **Supported Employment Program Objectives and Report on Consumer Progress**

*First Six Month Period:* Enter an "x" in the appropriate box during the first six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

*Comments/Summary of Achievements:* Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

*Second Six Month Period:* Enter an "x" in the appropriate box during the second six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

*Comments/Summary of Achievements:* Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

*Work Objective #:* Enter the work objective number and objective title

*Behavior or Other Work-Related:* Enter an "x" in the appropriate box if the objective is based on the consumer's behavior or other work-related issues.

*Measurement:* State what method the vendor will utilize to determine the consumer's progress.

*Goal:* State the goal of the objective.

*Services for Objective:* State the services that will be provided to meet the objective's goal.

*Person Responsible:* Provide the name(s) of the staff responsible for the objective services.

*Current Functioning:* State the consumer's current skill level related to the objective.

*Consumer Signature:* Have the consumer sign on this line.

*Date:* Enter the date the consumer signed the form. Enter date as mm/dd/yy.

*Conservator Signature:* Have the conservator or designated representative sign on this line.

*Date:* Enter the date the conservator or designated representative signed the form. Enter date as mm/dd/yy

*Supervising Staff Signature:* The supervising staff person signs on this line.

*Date:* Enter the date the supervising staff person signed the form. Enter date as mm/dd/yy.

<b>DDS Use Only: DDS will complete.</b>									
<b>Regional Center ID #:</b>									
	360	FDLRC	Frank D. Lanterman Regional Center						
	361	GGRC	Golden Gate Regional Center						
	362	SDRC	San Diego Regional Center						
	363	FNRC	Far Northern Regional Center						
	364	ACRC	Alta California Regional Center						
	365	SARC	San Andreas Regional Center						
	366	TCRC	Tri-Counties Regional Center						
	367	CVRC	Central Valley Regional Center						
	368	RCOC	Regional Center of Orange County						
	369	IRC	Inland Regional Center						
	370	RCRC	Redwood Coast Regional Center						
	371	NBRC	North Bay Regional Center						
	372	KRC	Kern Regional Center						
	373	ELARC	East Los Angeles Regional Center						
	374	SCLAR C	South Central Los Angeles Regional Center						
	375	HRC	Harbor Regional Center						
	376	WRC	Westside Regional Center						
	377	VMRC	Valley Mountain Regional Center						
	378	NLACR C	North Los Angeles County Regional Center						
	379	SGPRC	San Gabriel/Pomona Regional Center						
	380	RCEB	Regional Center of the East Bay						
<b>DOR Vocational Rehabilitation (VR) ID #:</b>									
	2218	VR	DOR Vocational Rehabilitation						
<b>Month Designations:</b>									
	January	JA	April	AP	July	JL	October	OC	
	February	FE	May	MY	August	AG	November	NO	
	March	MR	June	JN	September	SE	December	DE	