



NOTIFICATION OF TRANSFER TO EXTENDED SERVICES

State Form 56047 (6-16)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
VOCATIONAL REHABILITATION EMPLOYMENT SERVICES

This form is to be completed when the consumer, Vocational Rehabilitation (VR) Counselor, and provider staff agree that the named individual has benefited from VR funded Supported Employment services and is stabilized (consumer has achieved his/her highest level of independence) on the job.

NOTE: *Extended services cannot be billed until case is eligible for VR case closure.
Enclose Employment Support and Retention Plan.*

Name of consumer		Identification number	Social Security Number (last four (4) digits)
Source of extended services (i.e. Bureau of Developmental Disabilities Services (BDDS) Waiver, Medicaid Rehabilitation Option (MRO), Natural Supports, Other)			
If Other, please specify.			
Agency providing extended services (if applicable)			
Name of employment consultant			
Name of employer			
Average hours of extended services intervention per week	Average work (paid) hours per week		Average wage per hour
Provide a detailed description of the types of supports needed through Extended Services.			
Stabilization Date (into VR status '22') (month, day, year)		Date Extended Services will start (month, day, year)	

DISTRIBUTION:

When provider is a CRP: VR Counselor e-mails to local Bureau of Developmental Disabilities Services (BDDS) District Manager and to Community Rehabilitation Provider (CRP).

When provider is a Community Mental Health Center (CMHC): VR Counselor e-mails to local CMHC.