SCSEP Unsubsidized Employment Form

OMB Control Number: 1205-0040
Expiration Date: 8/31/2018

1. Name of participant___________________ 2. PID ___________________________

Employer Information

3. Name of employer____

4. Employer mailing address

____
a. Number and street, suite number; and/or PO Box

____
b. City

____
c. State d. ZIP code

5. FEIN_____________________________

6. Employer type

- ☐ Not-for-profit
- ☐ For-profit
- ☐ Government
- ☐ Self-employment

7. Is employer a host agency? ☐ Yes ☐ No

8. Did employer provide an OJE training site for this participant? ☐ Yes ☐ No

9. Employment site name and location____

9a. * Date for next customer satisfaction survey for this employer _________

9b. Employer continued availability ☐ Available ☐ Not available

*No data entry in SPARQ. Field is system-generated.

This reporting requirement is approved under the Paperwork Reduction Act of 1995, OMB Control No. 1205-0040. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number. Public reporting burden for this collection of information required to obtain or retain benefits (PL 109-365 Sec 501-518) is estimated to average 6 minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Investment, Room C-4510, 200 Constitution Avenue, NW, Washington, DC 20210 (PRA Project 1205-0040).

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Contact/Supervisor Information

10. Name of contact person____

11. Contact person's mailing address if different from number 4

____
a. Organization name

____
b. Number and Street, Suite Number; and/or PO Box

____
c. City

____
d. State e. ZIP Code

12. Contact person's title____

12a. Contact person's salutation ☐ Mr. ☐ Ms. ☐ Dr.

13. Contact person's phone number____

13a. Contact person's fax number____

13a1. Contact person's cell phone number____

13b. Contact person's e-mail address____

Complete fields 13c-13i if supervisor is different from contact person (number 10). If supervisor is the same as contact person, skip to field 14.

13c. Name of supervisor____

13d. Supervisor's mailing address if different from number 4

____
a. Organization name

____
b. Number and Street, Suite Number; or PO Box

____
c. City

____
d. State e. Zip Code

13e. Supervisor's title____

13f. Supervisor's salutation ☐ Mr. ☐ Ms. ☐ Dr.

13g. Supervisor's phone number____

13h. Supervisor's fax number____

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13h1. Supervisor's cell phone number____

13i. Supervisor's e-mail address____

Placement Information

14. Start date______________________(MM/DD/YYYY)

15. End date______________________(MM/DD/YYYY)

16. Starting wage per hour $____________________

17. Benefits (check all that apply)

☐ a. Health insurance
☐ b. Sick leave
☐ c. Pension/profit sharing
☐ d. Vacation
☐ e. Transportation
☐ f. Room and board
☐ g. Other__________(specify)
☐ h. None

18. At time of placement, is employment expected to be full- or part-time?

☐ Full-time ☐ Part-time

If part-time, number of hours per week expected_________

19. Job title____

19a. Participant's job code _________

1. Art, Design, Entertainment, Sports, and Media	8. Food Preparation and Service	15. Production, Assembly, Light Industrial
2. Business and Financial Operations	9. Healthcare	16. Protective Service
3. Community and Social Services	10. Legal	17. Retail, Sales, and Related
4. Computer and Mathematical	11. Maintenance and Custodial	18. Self-Employment
5. Construction, Installation, and Repair	12. Management	19. Transportation and Material Moving
6. Education, Training, and Library	13. Office and Administrative Support	
7. Farming, Fishing, and Forestry	14. Personal Care and Service	

19b. High-growth placement

☐ 1. Automotive
☐ 2. Advanced Manufacturing
☐ 3. Biotechnology
☐ 4. Construction
☐ 5. Energy
☐ 6. Financial Services
☐ 7. Geospatial
☐ 8. Health Care
☐ 9. Hospitality
☐ 10. Information Technology
☐ 11. Retail
☐ 12. Transportation
☐ 13. None

20. Training-related placement? ☐ Yes ☐ No

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21. Was placement the result of a substantial service provided to the employer by the sub-grantee? ☐ Yes ☐ No

21a. Type of supportive service provided:

☐ i. Dependent care (child or adult)

☐ ii. Health and medical services

☐ iii. Housing, including temporary shelter

☐ iv. Incidentals such as work shoes, badges, uniforms, eyeglasses, and tools

☐ v. Needs-related payments, such as utilities or food

☐ vi. Special job-related or personal counseling

☐ vii. Transportation

☐ viii. Other (specify)______________
____

21b. Date supportive service provided_________________________ (MM/DD/YYYY)

21c. Supportive service provided by:

☐ i. Grantee or sub-recipient/local project

☐ ii. Workforce partner

☐ iii. Both i and ii

☐ iv. Other (specify)_________________

22. Unsubsidized employment comments

Customer Service Survey Information

23. CS survey number 1___________Date of delivery____________ (MM/DD/YYYY)

24. CS survey number 2___________Date of delivery____________ (MM/DD/YYYY)

25. CS survey number 3___________Date of delivery____________ (MM/DD/YYYY)

Follow-up Information

26. *90-day date________________________________ (MM/DD/YYYY)

27. Has the participant returned to program within the first 90 days after exit?
☐ Yes ☐ No

27a. Has the participant re-enrolled in SCSEP within the first 90 days after exit?
☐ Yes ☐ No

28. Follow-up 1

a. *Scheduled date____________________ (MM/DD/YYYY)
b. Completed date____________________(MM/DD/YYYY)
c. Any wages for first quarter after exit quarter? Please also indicate method of verification

i. ☐ No wages
vi. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer
vii. ☐ Unable to obtain information
viii. ☐ Excluded

c1. If excluded, reason

i. ☐ Deceased
ii. ☐ Health/medical
iii. ☐ Family care
iv. ☐ Institutionalized

29. Follow-up 2

a. *Scheduled date________________________________(MM/DD/YYYY)
b. Completed date_________________________________(MM/DD/YYYY)
c. Any wages for second quarter after exit quarter? Please also indicate method of verification

i. ☐ No wages
vi. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer
vii. ☐ Unable to obtain information
viii. ☐ Excluded

c1. If excluded, reason

i. ☐ Deceased
ii. ☐ Health/medical
iii. ☐ Family care
iv. ☐ Institutionalized

d. If yes, earnings for second quarter after exit quarter $__________________

e. Any wages for third quarter after exit quarter? Please also indicate method of verification

i. ☐ No wages
vi. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer
vii. ☐ Unable to obtain information
viii. ☐ Excluded

e1. If excluded, reason

i. ☐ Deceased
ii. ☐ Health/medical
iii. ☐ Family care
iv. ☐ Institutionalized

f. If yes, earnings for third quarter after exit quarter $_______________

30. Follow-up 3

a. *Scheduled date___________________ (MM/DD/YYYY)
b. Completed date ___________________ (MM/DD/YYYY)

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c. Any wages for fourth quarter after exit quarter? Please also indicate method of verification

- i. ☐ No wages
- vi. ☐ Yes, supplemental through case management, participant survey, and/or verification with the employer
- vii. ☐ Unable to obtain information
- viii. ☐ Excluded

c1. If excluded, reason

- i. ☐ Deceased
- ii. ☐ Health/medical
- iii. ☐ Family care
- iv. ☐ Institutionalized

31. Customer satisfaction and follow-up comments.

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