SCSEP Unsubsidized Employment Form

OMB Approval 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.

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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 ~~or address field 1~~

_____

b. Number and Street, Suite Number; and/or PO Box ~~or address field 2~~

_____

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~~or address field 1~~

_____

b. Number and Street, Suite Number; or PO Box ~~or address field 2~~

_____

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

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20. Training-related placement? ☐ Yes ☐ No

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

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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)

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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