# SEAL31.TIFSTABILIZATION NOTIFICATION

State Form 56646 (R2 / 7-23)

FAMILY AND SOCIAL SERVICES ADMINISTRATION DIVISION OF DISABILITY AND REHABILITATIVE SERVICES VOCATIONAL REHABILITATION (VR) SERVICES

*The participant, employment consultant, and VR counselor must communicate regarding stabilization prior to submission of this form.*

|  |  |  |  |
| --- | --- | --- | --- |
| Participant: | Enter Participant Name | Employment Consultant (EC): | Enter EC Name |
| Date of Submission | Select date. | EC Contact Information: | Enter EC contract Information |
| VR IdentificationNumber: | Enter VR Participant ID  | VR Counselor: | Enter Counselor name |
| **Did employer offer healthcare benefits package?**Did Employer offer healthcare benefits package? | **Number of Hours participant is working:** Enter number of hours participant is currently working each week | **Hourly wage participant is currently receiving:** Enter hourly wage participant is currently receiving |

1. **Stabilization date *(month, day, year)*:** Select date, not to exceed current date.

# Has the participant reached his or her greatest level of independence?

*Monthly summaries should show that the participant has reached his or her greatest level of independence. Are natural supports in place? Will there be new tasks or hours? Has the EC faded supports as much as possible? Provide additional comments or notes below:*

Provide comments here.

# Are there any concerns that may affect job retention? Now or in the future?

*Examples may include assistive technology or transportation. Other concerns may include health, benefits or behavior. Identify the concern(s) and plans to address each topic.*

Identify the concern(s) and plans to address each topic.

1. **Will the participant use extended services to maintain employment? *Please select all that apply*:**

|  |  |
| --- | --- |
|  |  [ ]  No extended services needed |
|  | [ ]  Natural supports |
|  | [ ]  Bureau of Developmental Disabilities Services (BDDS) Extended Services[ ]  Medicaid Rehabilitation Option (MRO) |
|  | [ ]  VR Youth Extended Services\* |
|  | [ ]  Other *(please specify)* Provide details. |

**5. Who will be the provider for extended services?**

Click or tap here to enter text.

\***If seeking VR Youth Extended Services, please complete the following**. To be eligible for VR Youth Extended Services, a participant must be twenty-four (24) years old or younger, and have qualified for VR as most significantly disabled (MSD). To receive VR Youth Extended Services, the participant must be unable to receive support from any other source. If seeking this service, confirm the participant meets these conditions.

[ ]  Participant is twenty-four (24) years old or younger.

[ ]  Participant is most significantly disabled (MSD).

[ ]  Adequate natural supports are unavailable *(please explain)* Provide details.

[ ]  No other funding options are available *(please explain)* Provide details.

*This section should be completed by the Vocational Rehabilitation Counselor.* **VR approval or communication**

**of concerns regarding the stabilization date should occur within one (1) calendar week of form submission.**

[ ] Stabilization Date Approved.

[ ] Stabilization Date Not Approved.

VR Counselor *(Signature)*