

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
- Government

- For-profit
- 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 six 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)

- | | | |
|--|--|---|
| <input type="checkbox"/> a. Health insurance | <input type="checkbox"/> d. Vacation | <input type="checkbox"/> g. Other _____ (specify) |
| <input type="checkbox"/> b. Sick leave | <input type="checkbox"/> e. Transportation | <input type="checkbox"/> h. None |
| <input type="checkbox"/> c. Pension/profit sharing | <input type="checkbox"/> f. Room and board | |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> 1. Automotive | <input type="checkbox"/> 6. Financial Services | <input type="checkbox"/> 11. Retail |
| <input type="checkbox"/> 2. Advanced Manufacturing | <input type="checkbox"/> 7. Geospatial | <input type="checkbox"/> 12. Transportation |
| <input type="checkbox"/> 3. Biotechnology | <input type="checkbox"/> 8. Health Care | <input type="checkbox"/> 13. None |
| <input type="checkbox"/> 4. Construction | <input type="checkbox"/> 9. Hospitality | |
| <input type="checkbox"/> 5. Energy | <input type="checkbox"/> 10. Information Technology | |

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

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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)

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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

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- 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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