Employment Quality Payment Attestation with No Paystubs Form
For ECBDD Individual Budgets

Complete the following information to identify the provider of service and the individual who has achieved an outcome.

Provider Name	
Name of Individual Who Achieved Outcome	
ISP Span Year	

Check the box(es) in the Amount Requested column that corresponds to the appropriate acuity level and outcome(s) achieved. For individuals who achieve a placement in a competitive, integrated setting with at least $12/hour or 30 hours/week, both Job Development outcome payments can be claimed using the same payment form.

Job Development		
Outcome Achieved	**Acuity Level of Individual**	**Amount Requested**
Job Placement in Competitive, integrated setting	Acuity A or B	☐ $290
	Acuity C	☐ $430
Job placement in competitive, integrated setting (at least $12/hour or 30 hours week)	Acuity A or B	☐ $200
	Acuity C	☐ $300

Check the box(es) in the Amount Requested column that corresponds to the appropriate acuity level and outcome(s) achieved. Provide the calendar date that the individual achieved 90/180 days in the same job placement. Providers may claim the 90 day payment separately or wait to claim the 90 /180 day payments using one payment form.

Individual Employment Support (IES)		
Outcome Achieved	**Acuity Level of Individual**	**Amount Requested**
Job retention 90 days	Acuity A or B	☐ $230
	Acuity C	☐ $370
Date individual achieved 90 days in job:		
Job retention 180 days	Acuity A or B	☐ $170
	Acuity C	☐ $280
Date individual achieved 180 days in job:		

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COMPLETE THIS SECTIONONLY IF NO PAY STUB IS ATTACHED

If a paystub cannot be obtained to support the outcome payment, the following additional information is required:

Name of Employer	
Address of Employer	
Phone Number of Employer	
Date Individual Started Employment	
Has the Individual's Written Progress Report Been Updated?	
Hourly Wage	
Average Hours Worked per Week (Averaged Across 4 weeks)	

Name of Staff Person Providing IES/Job Development Services to the Individual: _____

Signature: _____Date: _____

*By signing this form, you attest that the information contained in this document is true.

Name of Administrative or Supervisory Staff Person: _____

Title: _____

Signature: _____Date: _____

*By signing this form, you attest that the information contained in this document is true.

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ECBDD INTERNAL USE ONLY

SSA Name: **Date SSA Received Form from Provider:**

SSA will email the completed form to SSA Specialist once reviewed and confirmed all requirements are met. Email will include applicable IB Service Authorization Form