MISSOURI REHABILITATION SERVICES FOR THE BLIND
WORK EXPERIENCE AGREEMENT

Date Begin _____ Ending Date _____

NAME OF EMPLOYER _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

INDIVIDUAL TO BE CONTACTED: _____

CONTACT EMAIL: _____

The employer identified herein agrees to participate in the Missouri Rehabilitation Services for the Blind work experience program by providing a work experience to:

NAME OF CLIENT: _____SS#_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP _____

in accordance with the terms set out herein and in Attachment B, and the special provisions set out in the WORK EXPERIENCE PROVISIONS AND ASSURANCES, Attachment A, which terms and special provisions shall be considered part of this agreement.

Missouri Rehabilitation Services for the Blind represented by the Counselor executing the agreement,

NAME OF COUNSELOR: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

EMAIL: _____
and the employer named above mutually agree to participate in the Missouri Rehabilitation Services for the Blind work experiences program in accordance with the terms and special provisions of this agreement.

_____ _____
Employer RSB Counselor

by_____ by_____
AUTHORIZED SIGNATURE AUTHORIZED SIGNATURE

_____ _____
TYPED NAME TYPED NAME

DATE SIGNED _____ DATE SIGNED _____

Attachment A
WORK EXPERIENCE PROVISIONS AND ASSURANCES

The items on this form shall be considered a part of attached agreement.

The occupation in which the client will be trained: _____

_____

I. **Concise outline of Work Experience**

Job tasks/Job duties:	**Hours (Total estimated time per task):**
A.	
B.	
C.	
D.	
E.	
F.	

II. **Goals**

Specific behavioral/work goals for client/trainee:	**Timeline to achieve goal:**
A.	
B.	
C.	
D.	
E.	
F.	

Counselor Review Schedule (Dates) _____

III. Hours, Employee wages, Employer reimbursement:

A. Total weekly work hours should be no less than _____hours per week, and no greater than _____ hours per week (hours per week shall not exceed 40 hours per week).

B. Wages to be received by the client/trainee (check one):

☐ Hourly ☐Weekly ☐Monthly Amount $_____

C. Employer's reimbursement from Missouri Rehabilitation Services for the Blind (check one):

☐ Hourly ☐Weekly ☐Monthly Amount $_____

Other arrangements: _____

_____

Attachment B

WORK EXPERIENCE
TERMS OF AGREEMENT

This agreement shall be binding on the parties for a term commencing on the begin date and terminating on the ending date, which dates are indicated on page one (1).
In return for entering into this agreement, Missouri Rehabilitation Services for the Blind promises:

A. to reimburse the employer for the work experience per the terms of the agreement.

B. to provide consultation and support to the client and employer on a regular basis.

C. to provide additional support or consultation on an as needed basis per the request of the client or employer.

D. In return for entering into this agreement, the employer promises to:

1. provide a meaningful work experience as agreed upon in the WBLE Provisions and Assurances document.

2. provide monthly (or more frequent if needed and agreed upon) written progress reports which will state:
   a. the activities engaged in by the client during the report period.
   b. the progress made by the client in each work activity; as measured by
   c. production reports or supervisory ratings or judgments.

3. pay wages to the client at least to the level of the applicable state or federal minimum wage.

4. provide the client the same working conditions as other similar employees.

5. shall pay the client wages for work produced when due on regularly scheduled paydays.

The employer and Missouri Rehabilitation Services for the Blind agree that the client shall be subject to the same rules and regulations that govern other employees. It is agreed that the employer retains the right to terminate the WBLE agreement if the client is disruptive to the work site, or if the employer-employee relationship is so poor as to make the work experience meaningless. However, the employer shall give Rehabilitation Services for the Blind at least five days' notice prior to termination.

Additional agreements, outside of those set forth in this document, between the employer, the client, or the Rehabilitation Services for the Blind counselor will require supervisory approval from Rehabilitation Services for the Blind prior to inclusion within this agreement.

Attachment C

RSB Work Experience Report

Employee (Trainee) Name:		
Authorization number:		
Site Name:		
Site Address:		
Site Phone:		
Supervisor	Start Date	End Date
Work Experience Position Title:		

Reporting period:
Hours worked this period:
(Certification for receipt of services should be attached)

Tasks/duties performed:

Progress made in each activity as measured by production reports or supervisory ratings:

Summary (Provide additional information regarding overall skills development, including soft skills):

Concerns (Note any concerns about the employee's performance here):

Attachment D

Certification of Receipt for Services

Department of Social Services/Family Support Division/Rehabilitation Services for the Blind

Client Name: _____

Provider Name: _____

Location of Services: _____

Service Description: _____

Date of Service	Time In	Time Out	Total Hours

Total Number of Hours Services Provided for the Month _____

I hereby certify that all services were performed as indicated above, and that all information is complete and accurate to the best of my knowledge. I understand that false or misleading information could be considered a breach of contract and may result in immediate termination of the contract.

_____ _____

Signature of Contractor/Service Provider* Signature of Client or Authorized Representative*

_____ _____

Date Date

**Signatures of the service provider and the Department client, or the client's Authorized Representative, are required. This document shall be submitted with the monthly invoice and monthly progress report before payment will be made by the Department.*