



**Allegheny County
Department of Human Services
Office of Community Services
Participant Performance-Based Status Report**

Participant Name: _____
Social Security # (last 4 digits): _____
Service Provider/Program: _____
Funding Title: _____
Effective Date: _____
CareerLink Case Manager: _____

Please check only one

Enrollment

Employment

Entered Employment Quarter

1st Retention Quarter

2nd Retention Quarter

***Other Outcome... deceased, institutionalized, health or family care**

No charge...participant no longer receiving services (please explain in comments:
*cannot locate, moved from area, no longer interested in services, removed for non-compliance,
etc.*)

.....
Employer Name: _____

Employer Address: _____

Employer Phone: _____

Contact Person: _____

Position: _____

Start Date: _____ **Job Title:** _____

Hours/week _____ **Wage/Hour** _____ **Health Insurance Offered** **Yes** **No**

Retention only:

Did participant remain with initial employer? _____

What was the approximate earning in the quarter? \$ _____

.....
Comments:

Agency Staff Name: _____

Agency Staff Signature: _____ **Date:** _____