Consumer Name and Address:

Counselor Name:

Counselor Phone:

Check if TDD

Counselor Email:

# INDIVIDUALIZED PLAN FOR EMPLOYMENT

My employment goal is:

My expected completion date is:

1. Why did we choose this employment goal?
2. These are the steps I need to accomplish to reach my employment goal:
3. These are the services we agreed are necessary to reach my employment goal:

Service Service Provider Funded By Start Date

1. How did we choose or arrange these services?
2. How and when will progress toward my employment goal be evaluated?
3. These are my responsibilities toward the cost of my Plan:
4. What additional services will I need after I reach my employment goal, if any?

**I ACKNOWLEDGE THE FOLLOWING STATEMENTS**

* I understand that I have the right to access records maintained by the Department containing my personal information by contacting my counselor. If the Department determines that any portion of my records may be harmful to me, the Department shall notify me in writing that the records cannot be directly disclosed to me and provide the options for releasing the records.
* I understand that except as authorized or required by state or federal law or regulations, my personal information maintained by the Department shall not be disclosed without my signed, informed written consent. See the attached Privacy Statement.
* I understand my right to make informed choices in the development of my individualized plan for employment, and I have exercised my right of informed choice in the development of my plan.
* I understand my right to make informed choices and have exercised informed choice in the selection of the specific employment goal, services, service providers, settings, and methods for arranging for services.
* My employment goal reflects my strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.
* I understand that my counselor has the responsibility to review, evaluate, and make a determination regarding approval of my plan.
* My counselor has reviewed my rights and responsibilities with me.
* I understand that my plan will be reviewed and evaluated periodically, at least annually, as defined in the plan.
* If changes need to be made to the plan, my counselor and I will discuss the changes and I will sign an amendment.
* I understand that the failure to participate, to cooperate, and/or make a reasonable effort to carry out my plan may result in the closure of my record of services and the loss of further services.
* I understand that I will only receive services and assistance that are necessary and reasonable for my education, training, and/or placement, and that if I am furnished any item or service that does not meet this standard, I will inform my counselor.
* I understand that the Department will review progress reports, grade reports, receipts, and may take other steps to verify purchases. My failure to provide requested information or the improper use of Department funds may result in my reimbursing the Department and could result in the Department closing my record of services.

By signing below, I acknowledge that my Rehabilitation Counselor has provided me with my Rights and Remedies (DR 1000) and has reviewed our roles and responsibilities with me. I understand that this Individualized Plan for Employment is effective only after the Rehabilitation Counselor and I sign the document, which includes all the attachments listed below.

|  |  |
| --- | --- |
| Consumer Signature: | Date Signed: |
| Parent/Guardian/Representative Signature (if needed): | Date Signed: |
| Rehabilitation Counselor Signature: | Date Signed: |

Attachment – DR 1000 Rights and Remedies

Attachment – Client’s Responsibilities

Attachment – Counselor’s Responsibilities

Attachment – Privacy Statement

Attachment – Ticket to Work (for SSI/SSDI Recipients)