



The SNAP Employment and Training Employability Plan

Case Name: _____ Caseworker: _____ Date: _____

Enter the appropriate component agreed upon with the client and indicate selected facility, referral and dates.

Program Component	Facility	Referral Date/Type	Entry Date	End Date
1. BASIC ED				
a) LIT/ABE				
b) HS/GED				
c) ESL				
2. JOB SEARCH				
3. JOB READINESS				
4. VOCATIONAL TRAINING				
5. WORK EXPERIENCE				
6. EARNFARE				
7. COMMUNITY WORK				

Employment Goal Plan

Employment Goal:

Intermediate Objective:



State of Illinois
Department of Human Services
The SNAP Employment and Training Employability Plan

6A(3 Years)

Supportive Services Needed:

Signature Section

I have reviewed and agreed to this plan.

Client: _____

Date: _____

Department Representative: _____

Date: _____

Distribution: Original - client, copy in case file



Client Reassessment - Progress Report

Completed by: _____

Date: _____

New Program Component:

Reason for New Plan of Action:

Changes from Original Full Assessment:

Supportive Services Needed:

Client Reassessment - Progress Report

Completed by: _____

Date: _____

New Program Component:

Reason for New Plan of Action:

Changes from Original Full Assessment:

Supportive Services Needed:



Client Reassessment - Progress Report

Completed by: _____

Date: _____

New Program Component:

Reason for New Plan of Action:

Changes from Original Full Assessment:

Supportive Services Needed:

Client Reassessment - Progress Report

Completed by: _____

Date: _____

New Program Component:

Reason for New Plan of Action:

Changes from Original Full Assessment:

Supportive Services Needed: