State of Illinois
Department of Human Services
Division of Rehabilitation Services

INDIVIDUALIZED PLAN FOR EMPLOYMENT

Customer Name:

Case Number:

Rehabilitation Counselor/Instructor:

Date:

Number:

Annual Review ☐

Change in Goal ☐

Change in Service ☐

GOAL

I understand that I am eligible to receive services through the Division of Rehabilitation Services (DRS) Vocational Rehabilitation program as I am an individual with a disability and need services to get, keep, advance in, or re-enter a job. I have chosen _____ as my goal and expect to achieve my employment outcome by _____.

I understand I may appeal any decisions or changes to my plan I do not agree with. I have been given my appeal rights and understand them. I understand I may call CAP for assistance at 1-800-641-3929 (V/TTY) to get help.

Based on my informed choice, my counselor and I have discussed the services and approved service providers necessary to reach my job goal and how to get those services. My counselor and I have selected the services and approved service providers listed below.

State of Illinois
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Customer Name: _____

Case Number: _____

SERVICES

Service:

Provider:

Start Date:

End Date:

Funding

Progress:

Service:

Provider:

Start Date:

End Date:

Funding

Progress:

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SERVICES

Service:

Provider:

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Progress:

Service:

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Progress:

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SERVICES

Service:

Provider:

Start Date:

End Date:

Funding

Progress:

Service:

Provider:

Start Date:

End Date:

Funding

Progress:

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Case Number: _____

SERVICES

Service: Provider: Start Date: End Date: Funding Progress:

SUPPORTED EMPLOYMENT PROGRAM

_____, _____, and_____ agree to the following Plan for On-going Support Services.

While this plan can be amended with the consent of the customer and counselor, it is anticipated _____ will start employment by working _____ hours per week with _____ hours of support per week. As we progress towards work independence, the rehabilitation team will consider this plan successful when _____ is working _____ hours per week with _____ hours of support per week.

In order to achieve this support reduction schedule, _____ will provide the following services, reported to the counselor _____ by _____:

When the customer's support has reduced to a consistent hourly level and the customer is consistently working _____ hours per week, the case will transition to the Extended Service system. The expected Extended Service arrangement will be _____. _____ has been identified as the expected provider of Extended Services. A new Plan will be written when the transition to Extended Services is made.

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At this time I do ☐ do not ☐ expect to need Post Employment Services, but will have my need reviewed before my case is closed.

Ticket to Work:

If you have been determined disabled by the Social Security Administration and qualify for the Ticket to Work Program, you agree to assign the DHS/Division of Rehabilitation Services your Ticket to Work by signing this Document.

X_____ _____ _____
Customer Date Parent/Guardian

_____ _____
Rehabilitation Counselor/Instructor Date

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Division of Rehabilitation Services

Customer Name:

Case Number: _____

Customer's personal and financial responsibilities in achieving the job objective are:

Comments: