

Individualized Plan of Employment (IPE)

Name: _____

Address: _____ Phone# _____

Disability: _____

My choice for an Employment Goal:

Expected Date of Employment: _____

Date Reviewed:

Signature

SLVR Counselor Signature:

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Intermediate Vocational Goals: _____

Are there other ways to pay for these services? _____ Yes _____ No
If yes, please list

Are personal assistance services including training in its management needed?
_____ Yes _____ No

Are assistive technology devices including training in management of the devices
needed? _____ Yes _____ No

My responsibilities for employment outcome are:

My progress will be measured by:

After I am employed and my VR case is closed, I may need the following post-
employment services:

If I do not follow through with my responsibilities listed in this plan, I may not reach my employment goal and my case may be closed.

I have been given contact information on how to seek assistance to resolve any disputes that I have regarding this plan.

The VR Counselor and I will review the plan on the dates listed above and I have my own copy of this plan.

I approved and participated in the planning of my IPE to the best of my ability.

Consumer's Signature

Date

Guardian's Signature

Date

SLVR Counselor Signature

Date