Individualized Plan for Employment
Options
and
Instructions

Options:

After your counselor has determined that you are eligible, he or she will talk with you about your job interests and the best way to reach your work goal. During this planning phrase you have the option of developing and writing all or part of the IPE:

- With the assistance of your counselor.
- You and/or your representative
- Or your counselor

Instructions:

Regardless of the option you choose the IPE must be mutually agreed upon and signed by your counselor and you the consumer. If you choose to write the plan on your own technical assistance will be available through the Client Assistance Program.

Attached you will find:

- Cover sheet
- IPE Instructions
- Attachment A (Expanded Definitions)
- IPE
- IPE Instructions
- IPE Amendment
- IPE Amendment Instructions

INDIVIDUALIZED PLAN FOR EMPLOYMENT

The Individualized Plan for Employment (IPE) must be developed in accordance with the Rehabilitation Act of 1973, as amended. The IPE (including amendments and closure statement) is that portion of the case record to be used to plan for services leading to employment outcome.

An IPE ***must*** be initiated once a specific employment outcome has been mutually agreed upon and executed on an agency-approved form for each eligible individual. Appropriate vocational rehabilitation services will be provided in accordance with the IPE and should be developed to reach a specific employment outcome.

The following elements must be included in the IPE, as appropriate:

- Specific employment outcome in the most integrated setting based on informed choice
- Outcome Date
- Specific services to be provided in order to achieve the employment outcome
- Provider of each service
- Each vocational rehabilitation service shall have an initial beginning date
- Supported Employment to include extended services and provider
- Comparable Benefits
- Evaluation Criteria
- Consumer Responsibilities
- DVR Responsibilities
- Post Employment Services

The IPE must be developed and/or redeveloped and signed jointly by the DVR specialist and the individual and, as appropriate the parent, guardian or other representative. The counselor and the consumer or the appropriate representative must sign the original IPE and all Amendments. The IPE must be reviewed at least annually and documented in your progress notes.

A copy of the IPE, Amendments and Employment Outcome, must be provided to the individual or, as appropriate, the parent, guardian, or other representative.

DVR will provide options for developing the IPE to the consumer. The options include, the IPE being written by the consumer on their appropriate representative, written jointly by the consumer and the DVR specialist, or written by the DVR specialist. If a consumer opts to write his/her own IPE it requires the approval of the DVR specialist and must be signed by both parties. The IPE must be written on the approved agency form.

Consumers expressing concerns or dissatisfaction with regard to the IPE should be advised of all appeal rights as specified in the Consumer Guide.

EXPANDED SERVICES DEFINITION

FOCUSED COUNSELING AND GUIDANCE: Counseling activity, which is aimed at the resolution of specific problems, which are substantial barriers to employment. Problems, counseling, strategies, approximate time frames for counseling contacts as well as expected or desired outcomes of counseling should be a part of the case record.

PERSONAL ASSISTANCE SERVICES: A range of services, provided by one or more persons, designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform in the individual did not have a disability. Such services can include an attendant for any individual with a disability, an interpreter for a p person who is deaf or hard of hearing, and a reader for a person with a visual impairment.

Personal assistance can be expected to last at least three months during the period of the IPE.

REHABILITATION TECHNOLOGY: Adaptive Equipment/Home, Vehicle or worksite Modifications: The application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronting individuals with disabilities in rehabilitation, employment, transportation, independent living and recreation. Rehabilitation technology may include structural, mechanical or other adjustments or design changes, for the purpose of increasing usefulness or access.

TRAINING: Any occupational skills training which exceeds the time frame normally required to achieve a specific vocational goal, or any training requiring a special setting or the provision of accommodation to a disability. This can include tutoring, note takers, interpreters, extended testing time, assistive listening devices, etc.

Class content tutoring unrelated to an individual's disability does not meet the requirement.

PHYSICAL RESTORATION: Medical, prosthetic/orthotic treatment, therapy or services required to address functional limitations resulting from the identified disability(ies).

Restoration services can be expected to last for at least three months during the period of VR services OR treatment beyond routine maintenance has been required for three months within the twelve months prior to the date of referral.

Physical Restoration does not include routine medical maintenance.

MENTAL RESTORATION: Therapeutic psychological, psychiatric or counseling intervention, either individual or group, required to address functional limitations resulting from the identified disability(ies). Mental health intervention can be expected to last for at least six months during the period of VR services or has been required for six months within the twelve months prior to the date of referral.

Peer support groups, i.e. AA, NA, etc., are not considered mental restoration.

JOB SEARCH/PLACEMENT ASSISTANCE SERVICES AND JOB RETENTION SERVICES: Job Placement services should be tailored to the specific needs of the individual, which results from the impact of the disability. These job services should require the unique expertise of the rehabilitation professional in order to achieve and/or maintain employment.

Revised 4/2000

INDIVIDUALIZED PLAN FOR EMPLOYMENT

Cabinet for Workforce Development-Department of Vocational Rehabilitation

NAME: _____ **SSN:** _____

SPECIFIC EMPLOYMENT OUTCOME (Work Goal): _____

I WILL COMPLETE MY WORK PLAN AND EXPECT TO BE WORKING BY: _____
(Mo./Yr.)

VOCATIONAL SERVICES NEEDED TO REACH MY GOAL:

SERVICE:	PROVIDER:	BEGINNING DATE:
Expanded Service ☐ Guidance & Counseling ☐ Rehab Technology ☐ Training ☐ Personal Assistance Services ☐ Physical Restoration ☐ Mental Restoration ☐ Job Search/Placement/Retention Assistance ☐ SSI/SSDI Recipient, No Expanded Service Needed		**(Mo./Yr.)**

☐ **I AM RECEIVING SUPPORTED EMPLOYMENT SERVICES AND MY EXTENDED SERVICE WILL BE:** _____

PROVIDED BY: _____

COMPARABLE BENEFITS THAT WILL BE USED TOWARDS REACHING MY GOAL:

BENEFIT	*SERVICE*	*BENEFIT*	*SERVICE*
☐ KTAP	_____	☐ State Mental Hospital	_____
☐ SSI/SSDI	_____	☐ Mental Health Facilities	_____
☐ DES	_____	☐ Pell Grant	_____
☐ One-Stop	_____	☐ Medicaid/Medicare	_____
☐ Veterans Benefits	_____	☐ Other _____	_____
☐ Workers Comp	_____	☐ Other _____	_____
☐ Private Health Insurance	_____	☐ Comparable Benefits Not Available	

CRITERIA USED TO EVALUATE PROGRESS TOWARDS EMPLOYMENT OUTCOME WILL BE: Obtaining and/or maintaining employment.

MY RESPONSIBILITIES:

- To cooperate in carrying out this program and actively participate in the attainment of my work goal.
- To participate financially in my Vocational Rehabilitation program to the best of my ability.
- To apply for and secure any and all comparable benefits and notify my counselor of receipt or denial of these benefits.

DEPARTMENT OF VOCATIONAL REHABILITATION RESPONSIBILITIES:

- To inform the consumer of choices during the Vocational Rehabilitation process.
- To coordinate and provide services without regard to race, creed, color, sex, national origin, age, or type of disability.
- To provide the consumer with a copy of their plan, and review your Individualized Plan for Employment annually, and amend as necessary.

I give permission for Vocational Rehabilitation and the school/facility of my choice to share financial and other information in order to carry out my Individualized Plan for Employment.

I understand that Department of Vocational Rehabilitation services depend on the availability of State and Federal Funds and/or openings at facilities/schools. If I have questions or concerns that cannot be addressed by my Rehabilitation Specialist, I will consult the Consumer Guide to find information on my rights, responsibilities, and the Client Assistance Program. I was given a copy of my Individualized Plan for Employment and am aware that my work plan will be reviewed annually.

_____ _____

Consumer Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Vocational Rehabilitation Counselor Signature Date

INSTRUCTIONS

for

INDIVIDUALIZED PLAN FOR EMPLOYMENT

Cabinet for Workforce Development-Department of Vocational Rehabilitation

NAME: *Consumer's full name*
SSN: *Consumer's 9 Digit social Security Number*
SPECIFIC EMPLOYMENT OUTCOME (Work Goal): *A description of the vocational goal that is mutually agreed upon and consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the eligible individual in the most integrated setting.*
I WILL COMPLETE MY WORK PLAN AND EXPECT TO BE WORKING BY: *Estimate the month and year you expect to start work.*
VOCATIONAL SERVICES NEEDED TO REACH MY GOAL: *Service refers to those activities that will be implemented to carry out the IPE. The expanded service is a mandatory component that identifies and addresses the severity of the disability. The provider section of the IPE is to identify who will be providing the service. The beginning date needs to be established for each service.*

SERVICE:	PROVIDER:	BEGINNING DATE:
Expanded Service ☐ Guidance & Counseling ☐ Rehab Technology ☐Training ☐Personal Assistance Services ☐Physical Restoration ☐ Mental Restoration ☐Job Search/Placement/Retention Assistance ☐SSI/SSDI Recipient, No Expanded Service Needed		**(Mo./Yr.)**

☐ *Check this box if the following is needed.* **I AM RECEIVING SUPPORTED EMPLOYMENT SERVICES AND MY EXTENDED SERVICE WILL BE:** *Identify the long-term service that will be required by the supported employment provider.* **PROVIDED BY:** *Indicate who will provide the service.*

COMPARABLE BENEFITS THAT WILL BE USED TOWARDS REACHING MY GOAL:
Check only those boxes that are related to a service planned above

.

BENEFIT	*SERVICE*	*BENEFIT*	*SERVICE*
☐ KTAP	_____	☐ State Mental Hospital	_____
☐ SSI/SSDI	_____	☐ Mental Health Facilities	_____
☐ DES	_____	☐ Pell Grant	_____
☐ One-Stop	_____	☐ Medicaid/Medicare	_____
☐ Veterans Benefits	_____	☐ Other _____	_____
☐ Workers Comp	_____	☐ Other _____	_____
☐ Private Health Insurance	_____	☐ Comparable Benefits Not Available	

CRITERIA USED TO EVALUATE PROGRESS TOWARDS EMPLOYMENT OUTCOME WILL BE:
Obtaining and/or maintaining employment. *Employment is the ultimate goal of this plan.*

MY RESPONSIBILITIES:

- To cooperate in carrying out this program and actively participate in the attainment of my work goal.
- To participate financially in my Vocational Rehabilitation program to the best of my ability.
- To apply for and secure any and all comparable benefits and notify my counselor of receipt or denial of these benefits.

DEPARTMENT OF VOCATIONAL REHABILITATION RESPONSIBILITIES:

- To inform the consumer of choices during the Vocational Rehabilitation process.
- To coordinate and provide services without regard to race, creed, color, sex, national origin, age, or type of disability.
- To provide the consumer with a copy of their plan, and review your Individualized Plan for Employment annually, and amend as necessary.

I give permission for Vocational Rehabilitation and the school/facility of my choice to share financial and other information in order to carry out my Individualized Plan for Employment.

I understand that Department of Vocational Rehabilitation services depend on the availability of State and Federal Funds and/or openings at facilities/schools. If I have questions or concerns that cannot be addressed by my Rehabilitation Specialist, I will consult the Consumer Guide to find information on my rights, responsibilities, and the Client Assistance Program. I was given a copy of my Individualized Plan for Employment and am aware that my work plan will be reviewed annually.

_____ _____
Consumer Signature Date

_____ _____
Parent or Guardian Signature Date

_____ _____
Vocational Rehabilitation Counselor Signature Date

INDIVIDUALIZED PLAN FOR EMPLOYMENT

Cabinet for Workforce Development-Department of Vocational Rehabilitation

AMENDMENT

Based upon mutual agreement, this will serve as an amendment to my Individualized Plan for Employment (IPE). I understand that all other elements of my original IPE are still in effect.

NAME: _____ **SSN:** _____

CHANGES IN: (check appropriate box and list changes)

- ☐ **Desired employment outcome:** _____
- ☐ **Service**
- ☐ **Service provider**

SERVICE:	PROVIDER:	BEGINNING DATE: (Mo./Yr.)

☐ **Changes in comparable benefits:** _____

_____

I WILL COMPLETE MY WORK PLAN AND EXPECT TO BE WORKING BY: _____

(Mo./Yr.)

I understand that Department of Vocational Rehabilitation services depend on the availability of State and Federal Funds and/or openings at facilities/schools. If I have questions or concerns that cannot be addressed by my Rehabilitation Specialist, I will consult the Consumer Guide to find information on my rights, responsibilities, and the Client Assistance Program. I was given a copy of my Individualized Plan for Employment and am aware that my work plan will be reviewed annually.

_____ _____

Consumer Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Vocational Rehabilitation Counselor Signature Date

INDIVIDUALIZED PLAN FOR EMPLOYMENT

Cabinet for Workforce Development-Department of Vocational Rehabilitation

AMENDMENT *INSTRUCTIONS*

Based upon mutual agreement, this will serve as an amendment to my Individualized Plan for Employment (IPE). I understand that all other elements of my original IPE are still in effect.

NAME: *Consumer's full name* **SSN:** *Consumer's 9 digit social security number*

CHANGES IN: (check appropriate box and list changes)

☐ **Desired employment outcome:** *Work Goal change*

☐ **Service** *Refers to those additional activities that will be implemented to carry out the IPE, as related to the disability.*

☐ **Service provider** *Refers to individual or entity delivering the service.*

SERVICE:	PROVIDER:	BEGINNING DATE: (Mo./Yr.)
		The beginning date needs to be established for each service.

☐ **Changes in comparable benefits:** *Any funding and/or services available to individuals that will be used before spending agency resources.*

I WILL COMPLETE MY WORK PLAN AND EXPECT TO BE WORKING BY: *Estimate the month and year you expect to start work*

I understand that Department of Vocational Rehabilitation services depend on the availability of State and Federal Funds and/or openings at facilities/schools. If I have questions or concerns that cannot be addressed by my Rehabilitation Specialist, I will consult the Consumer Guide to find information on my rights, responsibilities, and the Client Assistance Program. I was given a copy of my Individualized Plan for Employment and am aware that my work plan will be reviewed annually.

Signatures indicate agreement with all of the above statements.

_____ _____

Consumer Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Vocational Rehabilitation Counselor Signature Date