1. Employment Goal(s):
   a. Job title(s)
   b. Geographic location
   c. Work environment
      * If enclave or mobile work crew add justification

2. How many hours per week would the participant like to work?
   
   If the participant’s goal is to work less than 30 hours per week, please indicate the reason(s):
   
   □ Unable to work 30 hours due to limitations directly related to disability. Explain (utilize referral information):

   □ Participant is not seeking 30 hours or more
   □ Concern about loss of benefits
   □ Other, please explain:
3. Preferred work schedule:

   Is the participant available for evening and/or weekend shifts?  □ Yes  □ No
   If they are not, list the specific reason(s):

4. List individual’s wage expectation:

   If the per hour wage expectation is below minimum wage, please explain why:

5. Did the participant attend benefits advisement?  □ Yes  □ No
   If no, does the participant require benefits advisement prior to employment?  □ Yes  □ No

6. Does the participant understand the effect of income on benefits? Explain:

7. Does the provider recommend the VRC refer the participant for Benefits Advisement?  □ Yes  □ No

8. Will a PASS Plan be necessary?  □ Yes  □ No

9. List the individual’s key strengths/skills as observed or described in the referral, then apply them in your strategies below.

### Individualized Employment Related Barriers and Strategies:

PLEASE BE SPECIFIC IN DESCRIBING EMPLOYMENT RELATED BARRIERS AND INDIVIDUALIZED STRATEGIES.

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<tr>
<th>Barrier</th>
<th>Strategies</th>
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3. Additional pages may be included if more barriers and strengths exist.

**Employment Activities and Supports Services:**

**PLEASE DESCRIBE PLANNED ACTIVITIES**

These activities conducted by the service provider are required to be for a minimum of five hours monthly. This **must** include direct engagement with the participant as well as job development with potential employers.

<table>
<thead>
<tr>
<th>Activities/Supports</th>
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Additional pages may be included

10. Which agency will be the Extended service funding source?

- [ ] OMH
- [ ] OPWDD
- [ ] ACCES-VR
- [ ] ACCES-VR Extended Supported Employment for Youth
- [ ] OPWDD Application Pending (Specify current status):

11. Provide details regarding the need for long-term supports. Include anticipated needs and expectations for use of natural supports.

Is an off-site waiver being requested?

- [ ] Yes   - [ ] No   
  If yes, provide justification below.

Discussed with and agreed to by ACCES-VR VRC on the date listed below (Provider must maintain documentation of this in participant record):

- [ ] Yes   - [ ] No
  ____________________
  Date
This plan has been discussed with each of the partners listed below and they agree to the outline above. (Provider must maintain documentation of this in participant record)

☐ Yes ☐ No

Participant Signature: ________________________________ Date: ________________________________

Completed By:

Qualified Staff Signature ________________________________ Date: ________________________________

Printed Name ________________________________ Title: ________________________________
Phone Number: ________________________________ Email: ________________________________

Provider Supervisor:

Qualified Staff Signature ________________________________ Date: ________________________________

Printed Name ________________________________ Title: ________________________________

Please indicate the names of all individuals who will receive a copy of this plan.

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Form Revised Date: 11/1/18