

**Job Placement Services**

**Direct Placement Plan**

**Check Appropriate Box:**

**929X-Job Seeking and Development Services**

**935X-Job Seeking and Development Services (Deaf Service)**

|  |  |  |
| --- | --- | --- |
| AV#: | (7 digits) | Click to enter |
| ACCES-VR ID#: | (6 digits) | Click to enter |
| CAMS ID #: | (10 digits) | Click to enter |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| VR District Office: | Click to enter | Provider: | Click to enter | | |
| VRC Name: | Click to enter | NYS Fiscal System ID: | | | Click to enter |
|  | | Report Date: | | Click to enter | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant First Name: | Click to enter | | Participant Last Name: | Click to enter |
| Participant Phone Number: | | Click to enter | | |
| Participant Email Address: | | Click to enter | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | | |
| **Vocational Goal:** | Click to enter | | | | | | |
|  |  | | | | | | |
| **Barriers to Employment:** | | Click to enter | | | | | |
|  |  | |  |  |  |  |  |
|  |  | |  |  |  |  |  |
| **Please detail a plan for services** (Describe Services, Strategies and Activities): | | | | | | | |
| This may include but is not limited to workplace behavior training, job application training, job seeking skills training, interviewing skills training, and job retention skills training. It is expected that these activities conducted by the service provider would be for a minimum of ten hours monthly. | | | | | | | |
| Click to enter | | | | | | | |
|  | | | |  |  |  |  |
| **Next Steps:** | Click to enter | | | | | | |
|  |  | |  |  |  |  |  |
| **The provider is required to ensure the participant is registered at the local One-Stop Career Center?** | | | | | | | |
| Please enter NYS OSOS ID# | | | Click to enter | | | | |
|  |  | |  |  |  |  |  |
| Please note that an up-to-date resume is required to be submitted with the 929X/935X. | | | | | | | |
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| --- | --- | --- | --- |
|  |  |  | |
| Participant Signature: |  | Date: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Completed By:** | | | | |
|  | |  | Click to enter | |
| Qualified Staff Signature | |  | Date |  |
| Click to enter | |  | Click to enter | |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |