

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

1. General Information

Plan Number _____

Signature/Start Date _____

Expected Plan End Date _____

Plan Type- (circle one) Counseling & Guidance / Medical Restoration / Training

Supported Employment _____

Small Business Enterprise _____

Financially Eligible _____

Self Employed _____

Employment Goal _____

Custom Goal _____

Reason for Selecting this Employment Goal Checkbox List (At least one item or the narrative is required.)

A good choice given my abilities and disability. _____

I am currently doing this type of work. _____

I explored options and feel this is a good choice. _____

I have a job offer to do this type of work. _____

I have successfully done this type of work before. _____

It agrees with my IEP plan through my high school. _____

It matches my interests, abilities and strengths. _____

The job outlook for this type of work is good. _____

Other

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____
Caseload _____

How will this choice of employment goal lead to a job?

What steps are needed to reach the employment goal?

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____
Caseload _____

2. Planned Services

Assistive Technology Services Anticipated **yes/no**

See Attached Planned Service Data Sheet

How were these services arranged or chosen?

Total Costs

Participant	\$0.00
Others/Comparable Benefit	\$0.00
Agency	\$0.000
Source to be Determined	\$0.00
Total Plan	\$0.00

Describe the participant responsibilities towards the cost of the plan and securing comparable benefits.

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

3. Participant Responsibilities

Participant Responsibilities Checkbox List

I have a responsibility to return any equipment purchased for my by the agency if I no longer use it. _____

I understand that it is my responsibility to complete this plan and I will inform my counselor of changes. _____

I understand the importance of attendance and punctuality. _____

I will attend all scheduled meetings and appointments. _____

I will not quit my program or make any changes without contacting my counselor first. _____

I will report any address or telephone number change to my counselor immediately. _____

I will achieve satisfactory academic progress. _____

I will consistently look for employment _____

I will cooperate with all job placement efforts. _____

I will cooperate with my job coach to learn my job. _____

I will follow my treatment program. _____

I will follow-up on all employment leads provided. _____

I will maintain sobriety. _____

I will present my term/semester grade report. _____

I will take my medications as prescribed. _____

Participant Responsibilities Narrative

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

4. Documentation

Criteria for evaluating progress towards by (participant) employment goal. *

How often will progress towards by employment goal be reviewed?

What is the projected need for Post Employment Services?

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

Other Comments – Printed on Plan

Other Comments – Not Printed on Plan

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

4. Terms and Conditions

My signature, or that of my representative, affirms I understand that my progress toward this goal will be evaluated by me and my counselor according to the measure(s) of progress listed. This evaluation will occur no later than 12 months after the date of the IPE. I also affirm that my responsibilities, the agency's responsibilities, my rights, and remedies, including the Client Assistance Program (CAP) have been shared with me in a format that I understood; and these items are part of my IPE.

As a Ticket holder and recipient of SSI/SSDI I understand that I can (1) assign my Ticket to DBVI at any time; (2) leave my Ticket unassigned, or (3) assign my Ticket to another employment network.

___ Yes, ___ No, ___ N/A: I agree that by signing this original IPE my Ticket will be assigned to DBVI.

Post Employment Services

I have been informed of the availability of post-employment services. An assessment of my need for post-employment has been made. It is expected that I (will) (will not) need post-employment services.

Counselor Name _____

Caseload _____

Counselor's Signature _____

Client's Signature _____

Date _____

Client's Representative _____

Date _____

5. Rights and Responsibilities

MY RIGHTS AS A CUSTOMER

1. I may bring a parent, friend, or advocate to a meeting with my counselor or any DBVI representative.
2. I/my representative(s) have a right to participate fully in all decisions about my program and services.
3. DBVI may not discriminate against me because of my race, religion, sex, color, or disability.
4. Except where the law says it is OK to do so, my counselor may not release personal information about me/my case unless I agree.

INDIVIDUALIZED PLAN FOR EMPLOYMENT (IPE)

5. I understand I have the option to develop my own IPE on forms provided to me by my counselor, and if I elect to develop my own IPE, my counselor will assist me. Otherwise, my counselor will develop my IPE with my full participation.
6. My IPE will include "Rights and Responsibilities" my employment goal, the projected date for achieving my goal, the method to be used to measure my progress toward achieving my goal, and the progress review date. Services, service providers, and funding such as the contribution, comparable

benefits, and any cost I am responsible for will be included.

7. My IPE or any substantial amendment must be signed by me or my representative, and a copy of the IPE and any substantial amendment will be given to me.

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

8. I understand I can make choices regarding my employment goal, services, and service providers as long as federal, state or agency laws or policies aren't violated.
9. My IPE must contain a description of the specific vocational rehabilitation services that are needed to help me achieve my employment outcome. These services may include, as appropriate, the provision of assistive technology devices and services, and personal assistance services.
10. I understand that services will be provided in the most integrated setting (where there are individuals without disabilities) that is appropriate for the service involved but must be consistent with my informed choice.
11. My counselor and I will review my progress toward achieving my employment goal established on my IPE at least once a year (sooner if necessary) while my case is open. If substantial changes need to be made, my counselor and I must both agree to these changes, sign, and date the substantial amendment page of the IPE.
12. I understand my IPE or subsequent amendments will also be made available to me in an alternative format (i.e., braille or tape), upon my request.

Participant in Cost of Services

13. Participation in Cost of Services is determined based on 100% of normal living requirements of annual median income.
14. I understand it is the policy of DBVI that the Financial Determination/Redetermination Statement will be done every twelve months.
15. I understand that certain services are not based on financial need. These services include:
 - a. Assessment services to determine eligibility and the vocational goal.
 - b. Counseling and guidance and job placement.
 - c. Adjustment services provided by DBVI staff, including all VRCBVI services.
 - d. Rehabilitation technology services, including adaptive equipment for vocational training and/or employment.
 - e. Reader and interpreter services.
 - f. Personal assistance services.

DISAGREEMENTS ABOUT MY PROGRAM

16. I may disagree with my program and discuss my feelings/problems with my counselor and his/her supervisor.
17. If I disagree with any DBVI decision about providing me or denying me certain services, I may request an informal review of my case. I may also pursue mediation with respect to the decisions or I may request a

DBVI
Individualized Plan for Employment
12/30/2015

Fair Hearing conducted by an Impartial Hearing Officer. *I understand mediation is optional, and it will not replace my right to a fair hearing. I also understand if I decide to pursue mediation as an option it must be agreed to by me and DBVI. *

18. I may request assistance from the Client Assistance Program (CAP) at the disAbility Law Center of Virginia if I am unhappy with DBVI services or decisions. The CAP toll-free phone number is 1-800-552-3962 (Voice/TDD).

**Individualized Plan for Employment
Department for the Blind and Vision Impaired**

Participant _____ **Participant ID** _____

Caseload _____

19. I may request DBVI to provide transportation, interpreter services and/or reader services if I need these services to participate in a Fair Hearing.

MY RESPONSIBILITIES AS A CUSTOMER

1. To continue to receive DBVI services, I have to follow through with the steps that my counselor and agreed to and make satisfactory progress towards reaching my goal.
2. I may have to pay for certain services, if I am financially ineligible, and I agree to answer all of my counselor's questions about my family size, income, and other information. DBVI financial guidelines will be explained to me by my counselor, and I may obtain written copies of these guidelines.
3. I understand that the agency is required to utilize comparable benefits in paying for services; therefore, I must cooperate in this effort by applying for available grants, etc.
4. I will keep all of my appointments and follow through with training requirements. If I cannot make an appointment or need to be absent from training/other services, I will explain to my counselor why I had to be absent.
5. I will inform my counselor about changes which could affect my program such as change in address, telephone number, employment goal, medical insurance, job status, income level, family size, eligibility for services and benefits from another agency or agencies, including changes in benefits that I receive such as SSI, unemployment insurance, and grants/scholarships, etc.
6. If I do not use DBVI-provided tools, equipment, or training supplies properly or if I drop out of my program, I may be required to return these items to DBVI.
7. I understand that the services listed in this IPE are needed for me to reach my employment goal, and I agree to meet all of my responsibilities.