

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

**Participant** \_\_\_\_\_ **Participant ID** \_\_\_\_\_  
**Caseload** \_\_\_\_\_

**1. Services Description**

**Plan Number** \_\_\_\_\_

**Service Category** \_\_\_\_\_

**Procedure Description** \_\_\_\_\_

**Description**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Estimated Start Date** \_\_\_\_\_

**Estimated End Date** \_\_\_\_\_

**Estimated End Date or Event** \_\_\_\_\_

**My Chosen Provider** \_\_\_\_\_

**2. Estimated Service Costs**

<b>Participant</b>	\$ _____
<b>Others/Comparable Benefit</b>	\$ _____
<b>Agency</b>	\$ _____
<b>Source to be Determined</b>	\$ _____
<b>Total Service</b>	\$ _____

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**Caseload** \_\_\_\_\_

**Source of Comparable Benefits Checkbox List**

- |                                  |                         |
|----------------------------------|-------------------------|
| _____ Employer medical Insurance | _____ Family            |
| _____ JTPA                       | _____ Medicaid          |
| _____ Medicare                   | _____ None              |
| _____ Other                      | _____ PELL Grant        |
| _____ Pending Litigation         | _____ Private Insurance |
| _____ VA Grant                   | _____ VA Medical        |
| _____ Worker's Compensation      |                         |

**3. Service Completion**

**Actual End Date** \_\_\_\_\_

**4. Comments**

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