NAME OF CRP:

**Discovery/Exploration Service Plan**

*\*D/E Service Plan is used in conjunction with the Vocational Planning Guide (VPG) and/or referral documentation. Service planning is a collaborative involving the person served, their support team, VR and CRP team members?*

| **Referral Information** | **D/E Planning Conference Date**: |
| --- | --- |
| Referring Counselor: | **D/E Start Date** (*Within date range on VR Authorization) :* |

CRP Team Member(s) assigned:

| **What is your name?** |  |
| --- | --- |
| First Name: | Last Name: |
| Middle Name: | “Preferred” Name: |
| Previous Last Name: | Social Security #:    -  - |
| Birth Date: | Gender:       Race: |

| **What is your address?** |  |
| --- | --- |
| Home Address: | City: |
| State: | Zip: |
| County: |  |
| *Mailing Address (If same as above check here:* ) |  |
| Address: | City: |
| State: | Zip: |

| **What is your phone number and email address?** |  |
| --- | --- |
| Primary Phone:    -   - | Voice  TDD/TTY/TEXT  Video |
| Secondary Phone:    -   - | Voice  TDD/TTY/TEXT  Video |
| Email: |  |

| **Communication:** | **Additional Information/Objective Needed**. |
| --- | --- |

Do you have reliable means of communication including receiving messages?

Yes  No  Explain:

What is your preferred method of communication?

| **What is your marital status?** |
| --- |
| Single  Divorced  Married  Separated  Widow/Widower |

| **Do you have a guardian/payee?** | (*If no guardian/payee, check here:* *)* |
| --- | --- |
| Guardian Name(s): |  |
| Address: | City: |
| State: | Zip: |
| Primary Phone:   -   - | Voice  TDD/TTY/TEXT  Video |
| Secondary Phone:   -   - | Voice  TDD/TTY/TEXT  Video |
| Email: |  |
| Payee Name(s): |  |
| Address: | City: |
| State: | Zip: |
| Primary Phone:      -     - | Voice  TDD/TTY/TEXT  Video |
| Secondary Phone:     -     - | Voice  TDD/TTY/TEXT  Video |
| Email: |  |

**DESIGNING YOUR SERVICES AND DEFINING YOUR GOALS**

The following is a list of questions and potential activities you and your team can use to design your services. These will assist you to identify and learn about your strengths, needs, abilities and preferences while exploring and defining your goals. Your team will explain these activities and will help you pick the services you feel will help you decide of goals to explore.

1. What are your personal and employment goals?
2. What do you need to achieve your goals and how can our services help you achieve them?

1. What are your strengths and abilities, and how might these help achieve your goals?
2. What are your preferences/conditions for work (hours/shifts, wage/benefits, commute, environment)?
3. Do you have any upcoming events (medical, planned relocation, legal concerns, family needs, and trips) that would present difficulty to your participation in services designed to help you choose a job goal, look for work and start a job?
4. Can you tell us how your disability(ies) and/or barriers affect your ability to achieve your goals?
5. Are you comfortable with your disability being disclosed with potential employers and other entities? Yes  No Explain:

What can you tell us about your interests, hobbies, and things you like?

What can you tell us about things you do not like?

**Disability Information:**

| Primary Disability: | Due To: |
| --- | --- |
| Secondary Disability: | Due To: |
| Additional: | Due To: |
| Self-Reports: | Due To: |

| **Current Support Network:** | **Additional Information/Objective Needed.** |  |
| --- | --- | --- |
| **Support Person** | **Relationship to Client** | **Contact information** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Are you currently receiving case management/other support services? Y N (i.e. Reg. office, Probation/Parole, etc….)

| **Support Service Agency** | **Contact Name** | | **Contact Information** |
| --- | --- | --- | --- |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
| **Can you tell us about your childcare needs?** | | **Additional Information/Objective Needed.** | |
| Number in Family:       Parent: Yes  No | | If Yes, number and age of dependents? | |
| If yes, do you have reliable childcare? | | Yes  No  If Yes, explain: | |
| Do you have a backup plan? | | Yes  No  If Yes, explain: | |

| **Transportation Planning:** | **Additional Information/Objective Needed.** |
| --- | --- |
| Do you have reliable transportation? | Yes  No  Explain: |
| Do you have a backup plan? | Yes  No  Explain: |

| **I-9 documentation needed to be hired:** | **Additional Information/Objective Needed** |
| --- | --- |
| Do you have required two forms of identification for and I-9? | Yes  No  If No, action is needed. |

If yes, what are they? (Must have at least 1 from List A, or 1 each from Lists B and C)

*\*Select from most commonly used list below and/or consult official I-9 form instruction sheet for additional options.*

**List A**: US Passport  Alien/permanent Resident Card  Unexpired Authorization for Employment

**List B**: Valid DL  Military ID  State ID  School ID w/ Photo

Voter ID card

**List C**: Social security Card  Birth Certificate  US Citizenship Card  Certificate of birth abroad

| **What can you tell us about your living arrangement?** | **Additional Information/Objective Needed**. |
| --- | --- |

Private Residence  Group Home  Foster Care  Homeless  Other  explain:

Supported Living  Is 24 hour line sight supervision required? Yes  No  If Yes, supervision requirements must be discussed.

If receiving home supports, list the following information about supporting agency:

| Name of Provider: | Primary Source of Support: |
| --- | --- |
| Address: | City: |
| State: | Zip: |
| Primary Phone:    -   - |  |
| Secondary phone:    -   - |  |

Do you feel safe and secure in your current living arrangement? Yes  No  (If No, explain)

| **What can you tell us about your income and benefits?** | **Additional Information/Objective Needed.** |
| --- | --- |
| Gross Monthly Family Income: | Primary Source of Support: |
| Other Source (s) of financial Support: |  |
| Do you have child support and/or alimony payments? | Yes  No  If yes, amount? $ |
| Are you behind on any of these payments? | Yes  No  If yes, amount? $ |
| Other outstanding debts/wage garnishments? | Yes  No  If yes, amount? $ |
| SSI: $       SSDI: $  Food Stamps: | TANF: $      Work Comp: $ |
| Residential/Support Services: $ | Explain: |
| Other: $      explain: |  |
| *Medical insurance information*  (Check type of insurance applicable) |  |
| Medicare | Private |
| Medicaid | Worker’s Compensation |
| None | Other  explain: |

Insurance comments:

What is your understanding of how your benefits will be impacted by going to work?

If you have benefits, would you like assistance with benefits planning? Yes  No  (If No, explain)

| **What is your education and/ or training background?** | **Additional Information/Objective Needed.** |
| --- | --- |
| High School: In Progress Diploma  GED/HSET | Did not complete |
| Year graduated: | Last Grade completed: |
| Special Ed./IEP/504: Yes  No |  |
| High school (Name/Location): | |

*If you don’t have a diploma or high equivalency, would you like assistance obtaining these?* Yes No

Do you have post-secondary or training experience?

Technical School  College  Other  Explain:

Degree/Certificate Received: Yes  No

Years Received:       Type: Certificate  Associates  Bachelors

Masters  Doctoral

If no, do you plan to return? Yes  No  Field of Study/ Major:

Name/location of program:

Comments/Other pertinent education or training information:

| **Can you tell us about any legal issues?** | **Additional Information/Objective Needed.** |
| --- | --- |
| Are you on Probation/Parole? | Yes  No  If yes, explain: |
| Do you have a felony on your record? | Yes  No  If yes, explain: |
| Do you have a misdemeanor on your record? | Yes  No  If yes, explain: |
| Are you a registered sex offender? | Yes  No  IF yes, explain: |
| Do you have any outstanding warrants? | Yes  No  If yes, explain: |
| Any other legal/ civil matters to discuss? | Yes  No  If yes, explain: |

\**If you have said yes to the above, information will be provided concerning the relationship/collaboration between criminal justice entities and your service provider.*

Do you have a history of drug/alcohol dependence? Yes  No  If yes, explain:

Can you pass a drug screening today? Yes  No  If no, explain:

| **Other Considerations**: | Additional Information/Objective Needed. |
| --- | --- |

Do you have any personal considerations that we should be aware of during your participation in services and/or achieving your goals? Yes  No  Explain:

| **Assistive Technology:** | **Additional Information/Objective Needed**. |
| --- | --- |

What is your understanding of assistive technology and how it may help you in achieving your goals?

| **Accommodations:** | **Additional Information/Objective Needed**. |
| --- | --- |

What is your understanding of workplace accommodations and how they may help you in achieving your goals?

| **Work/Volunteer Information:** | **Additional Information/Objective Needed** |
| --- | --- |

What can you tell us about your recent work history?

What volunteer activities are you/have you been part of?

| **Potential health and/or safety risks identified?** | **Additional Information/Objective Needed**. |
| --- | --- |

\**Add as many potential risks as necessary*

While developing this plan, my service provider and I, as well as my family/support network, if applicable, have had opportunity to discuss and assess potential risks associated with my participation in services and pursuit of my goals.

Potential Risks:

**My team and I have discussed that my services include consideration of relevant**: school records, social information, psychological information, previous direct services and supports, assessments, medical history and other records when available.

Along with the “**Additional Information/Objective Needed**” items previously checked, I have chosen each checked **Objective** below as part of my career planning services:

| Interviews with my family | Interviews with my support staff |
| --- | --- |
| Observations of me in my ideal environment | Interviews with school personnel |
| Discuss/observe my hobbies/interests | Observations of me at my school work experience |
| Explore my typical day | Labor market research |
| Community Based Assessments | Set up volunteer experiences |
| Interest Inventories/Vocational testing | Job Shadowing |
| Review/establish my MO Connections profile/resources | Identify my existing network of contacts within business community |
| compare my work preferences/ conditions with my local labor market | Explore additional work readiness areas (attire, hygiene, work appropriate conversations, etc.…) |

Identify/access resources to address my:

| physical health needs | mental health needs | substance dependence recovery needs |
| --- | --- | --- |
| advocacy needs | educational goals/needs | financial planning needs |
| housing needs |  |  |

Use of technology (internet, computer, smart phone, tablet, software

Benefit from additional community resources (DMH, AEL, Library, Ind. Living Center, etc.)

Other Activity:

**What Jobs/Job Interests were discussed during the planning conference?**

**Additional Planning Conference Summary or Service Plan Notes:**

**Address each “Additional Information/Objective Needed” selected in the Service Plan**

**Objectives recommended for career planning MUST include, but not be limited to, Accommodations, Health and/or Safety Risks, Community Based Assessments, Assistive Technology, and Transportation. \**See D/E Reference Sheet***

| **Objective** | **Action Steps** | **Person(s) responsible** | **Frequency** | **Start**  **Date** | **Estimate Completion Date** | **How will the Objective be measured?** | **Periodic Review** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *(What is needed and why?)* | *(How will it get completed?)* | *(Who will do it?)* | *(How often or how many time?)* | *(When starting?)* | *(When will it be done?)* | *(How will we know the activity is complete?)* | *(Reviewed, dated and initialed)* |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |
| Objective |  |  |  |  |  |  |  |

I (and my family/support team if applicable) was/were actively involved in service planning meetings, choosing services and developing this Service Plan. I understand that I am responsible, along with those supporting me, for implementing the objectives described in my Service Plan. I (and my family/support team if applicable) agree with participating in the action steps as defined and understand my plan can be reviewed, modified and updated with my team as needed

| Person Served | Date |
| --- | --- |

| Guardian (If applicable) | Date |
| --- | --- |

| CRP Team Member | Date |
| --- | --- |

***\*\*\*Describe reviews and any necessary modifications or updates needed below. Sign and date the Service Plan changes.***

Description of Service Plan Change:

| Person Served | Date |
| --- | --- |

| Guardian (If applicable) | Date |
| --- | --- |

| CRP Team Member | Date |
| --- | --- |