Kentucky Office of Vocational Rehabilitation
Individualized Plan for Employment (IPE)

Name: _____ Case Number: _____

IPE Goal: Employment Outcome or PPSEO-Choose one

_____

Employment Outcome/Goal: _____ SOC: _____
I will complete my work plan and expect to be working by: _____

Projected Post-School Outcome (PPSEO): _____Code: 099999
*I will complete my work plan and expect to have completed my PPSEO by: _____

The following Vocational Services are needed to reach the Specific Employment Outcome/PPSEO listed above:

Service: _____
Service Specifics:

_____
Vendor / Service Provider Name: _____
Service Beginning Date: _____
Other Comments:

_____

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Service Specifics:

_____
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Service Specifics:

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Service Beginning Date:
Other Comments:

Service:
Service Specifics:

Vendor / Service Provider Name:
Service Beginning Date:
Other Comments:

Resources Available to me that I will use throughout my rehabilitation program:

Service Provider _____ Service _____

Service Provider _____ Service _____

Service Provider _____ Service _____

Service Provider _____ Service _____

Service Provider _____ Service _____

Other Service: _____

Supported Employment information- (Pick one) _____

The extended services I will need after my case is closed is:

Provided by:

Criteria used to evaluate progress towards employment outcome will be: Obtaining and/or maintaining employment.

My responsibilities:

- **To inform my counselor of any changes in my situation and provide any documentation/information in a timely manner as needed.**
- To cooperate in carrying out this program and actively participate in the attainment of my work goal.
- To participate financially in my Vocational Rehabilitation program to the best of my ability.
- To *apply* for and secure any and all comparable benefits and notify my counselor of receipt or denial of these benefits.

Office of Vocational Rehabilitation Responsibilities:

- To inform the consumer of choices during the Vocational Rehabilitation process.
- To coordinate and provide services without regard to race, creed, color, sex, national origin, age, type of disability, genetic information, marital status, sexual orientation, gender identity, citizenship, pregnancy, veteran status, or any other status protected by applicable law.
- To provide the consumer with a copy of the plan, and review your Individualized Plan for Employment annually as required by law without which the case would have to be closed, and amend as necessary.

☐ I agree that consumer status information may be shared with Workforce Development partners as needed to confirm employer's eligibility for Work Opportunity Tax Credit.

Supplemental Security Income (SSI-Blind or SSI-Disabled) and Social Security Disability Insurance (SSDI) Recipients

The Social Security Administration considers my Ticket to Work (TTW) to be "in-use" upon signing this plan with the Office of Vocational Rehabilitation (OVR). I am aware that OVR will submit my information to MAXIMUS, the TTW Operations Support Manager, to indicate my participation. Continuing Disability Review (CDR) protection is an incentive of the TTW program. I understand that I am responsible for meeting the TTW timely progress requirements to maintain my CDR protection and that OVR may report my progress upon request to MAXIMUS. I understand that CDR protection may be extended after case closure if I assign my TTW to an Employment Network within 90 days. If I have additional questions or concerns about TTW, I can call 1-866-968-7842 (TTY 1-866-833-2967) for further information.

The National Registration Act of 1993 states that the agency must offer an opportunity to register to vote at application and if there is an address change. Has the consumer had an address change, name change, or voter eligibility status change at this time?

☐ Yes ☐ No

If yes, please make the appropriate box.

Voter Registration ☐ Offered ☐ Completed (Date counselor mailed to clerk's office) _____ ☐ Already registered ☐ Declined

Has the individual achieved a diploma, degrees, certificates, license, or credential?

Training Credentials: _____

Other Diploma, Degree, Certificate, or credential: _____

Date Achieved: _____

I give permission for Vocational Rehabilitation and the school/facility of my choice and/or SSA to share financial and other information in order to carry out my Individualized Plan for Employment. I understand that Office of Vocational Rehabilitation services depend on the availability of State and Federal Funds and/or openings at facilities/schools. If I have questions or concerns that cannot be addressed by my Rehabilitation Counselor, I will consult the Consumer Guide to find information on my rights, responsibilities, and the Client Assistance Program. I was given a copy of my Individualized Plan for Employment by mail or electronically and am aware that my work plan will be reviewed annually.

Consumer Signature	Date
Parent or Guardian Signature	Date
Vocational Rehabilitation Counselor Signature	Date
Branch Manager Signature (if applicable)	Date
Director of Field Services Signature (if applicable)	Date
Rehabilitation Technology Branch Manager Signature (if applicable)	Date

This IPE is not in effect until signed by the consumer (and/or parent or guardian as appropriate) and the counselor.