OVR 7

(Rev. 01/2026)

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

Kentucky Career Center
Vocational Rehabilitation

1. INDIVIDUAL INFORMATION

Name	Case Number

Employment Goal:	
◯ Employment Outcome ◯ Projected Post-School Employment Outcome	
SOC Code	**I will complete my work plan and expect to be working by (MM/DD/YYYY)**

2. SUPPORTED EMPLOYMENT

Supported Employment Status
Extended *(i.e., Long-term support)* services needed
Extended Services provided by

Criteria used to evaluate progress towards the employment outcome will be the provision of the following services and/or comparable benefits.

3. VOCATIONAL SERVICES

The following vocational services paid for by the Office of Vocational Rehabilitation (OVR) are needed to reach the specific employment outcome/PPSEO listed above:

Service 1

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	

Vendor or Service Provider Name
Funding Source(s)

Service 2

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 3

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 4

Service	Begin Date *(MM/DD/YYYY)*

Detailed description or service specifics
Vendor or Service Provider Name
Funding Source(s)

Service 5

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 6

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 7

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

4. COMMENTS

Provide Additional Comments or Details

5. COMPARABLE BENEFITS

If applicable, provide information about any Comparable Benefits available to the individual that they will use throughout their rehabilitation program not purchased by OVR.

Comparable Benefit 1

Service	Provider
Description of Service(s) Provided	

Comparable Benefit 2

Service	Provider
Description of Service(s) Provided	

Comparable Benefit 3

Service	Provider
Description of Service(s) Provided	

Comparable Benefit 4

Service	Provider
Description of Service(s) Provided	

Comparable Benefit 5

Service	Provider
Description of Service(s) Provided	

6. INDIVIDUAL RESPONSIBILITIES

- To inform my counselor of any changes in my situation, including my address 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 all comparable benefits and notify my counselor of receipt or denial of these benefits.

7. OFFICE OF VOCATIONAL REHABILITATION RESPONSIBILITIES

- To inform the individual 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 individual 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 amended as necessary.

☐ I agree that individual status information may be shared with Workforce Development partners as needed to confirm employer's eligibility for the Work Opportunity Tax Credit (WOTC)

8. SUPPLEMENTAL SECURITY INCOME *(SSI BLIND OR SSI DISABLED)* OR 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 the Ticket Program Manager, to indicate my participation whether I am a current Ticketholder or become eligible for TTW while my OVR case is open.
- 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 the Ticket Program Manager.
- 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.

9. VOTER REGISTRATION

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 individual had a recent address change, name change, or voter eligibility status change?		
◯ Yes	◯ No	
If yes, please select the appropriate option		
◯ Already Registered	◯ Completed	◯ Declined

10. EDUCATION / TRAINING / SKILLS

If the individual has achieved a diploma, degrees, certificates, license, or credential since they have applied for services, please complete this section, otherwise skip to the next section.

Training Credentials	
N/A	
Other Diploma, Certificate or Credential	**Date Achieved (MM/DD/YYYY)**

11. PERMISSION AND SIGNATURES

- I give permission for Vocational Rehabilitation and the school/facility of my choice and/or SSA to share financial and other information to carry out my Individualized Plan for Employment (IPE).
- I understand that the Office of Vocational Rehabilitation (OVR) 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 Guide to KY OVR Services to find information on my rights, responsibilities, and the Client Assistance Program.
- I was given a copy of my Individualized Plan for Employment (IPE) by mail or electronically and am aware that my work plan will be reviewed annually.

Individual's Signature _____ Date (MM/DD/YYYY) _____

Parent / Guardian Signature _____ Date (MM/DD/YYYY) _____

Vocational Rehabilitation Counselor's Signature _____ Date (MM/DD/YYYY) _____

Branch Manager's Signature (if applicable) _____ Date (MM/DD/YYYY) _____

Director of Field Services Signature (if appliable) _____ Date (MM/DD/YYYY) _____

Assistive Technology Branch Manager Signature (if applicable) _____ Date (MM/DD/YYYY) _____

The counselor must be the last individual to sign the IPE, and it is the date of that signature that signifies that the IPE has been implemented.