Education Cabinet
Office of Vocational Rehabilitation
OVR 5 TRIAL WORK EXPERIENCE PLAN

Name: _____ **Case Number:** _____

My counselor and I agree that I have a disability that affects my ability to work. In order to explore how well I can do on different jobs as part of the eligibility decision, OVR will provide the following services and work experiences.

EXPECTED DATE TO COMPLETE TRIAL WORK EXPERIENCES OR EXTENDED EVALUATION:

_____
(M/Y)

The following Vocational Services are needed:

Service: _____
Service Specifics:

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

_____

Service: _____
Service Specifics:

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

_____

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Service Specifics:

_____
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Other Comments:

_____

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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: _____

CRITERIA USED TO EVALUATE PROGRESS WILL BE: Successful completion of work or evaluation tasks as assigned.

My responsibilities:

- ❖To cooperate in carrying out this program and actively participate in planned work experiences.
- ❖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 provide multiple realistic trial work experiences in the most integrated setting possible.
- ❖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, or type of disability.
- ❖To provide the consumer with a copy of the plan.

I give permission for Vocational Rehabilitation and the school/facility of my choice 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 Trial Work Experience Plan and am aware that my eligibility for Vocational Rehabilitation Services will be determined after I complete my trial work experience and/or extended evaluation plan as amended.

Consumer Signature	**Date**
Parent or Guardian Signature	**Date**
Vocational Rehabilitation Counselor Signature	**Date**

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