Goodwill Industries of Central Florida, Inc. Building Lives That Work.

INDIVIDUALIZED TRAINING PLAN

7531 South Orange Blossom Trail
Orlando, Florida 32809

Client Name: _____ **Date:** _____

Vocational Training Specialist: _____

DESCRIPTION OF THE PLAN

Your Work Adjustment Program is a coordinated team effort; you are the captain of the team. As with any team, each member has roles and responsibilities. If any member of the team fails to pull their own weight, the team cannot be successful and reach its goal. The team's goal is your successful completion of the program and eventual employment . To meet that goal, we have outlined the following roles and responsibilities for each member of the team.

The plan outlines not only the barriers which make it difficult for you to obtain a job, but also your strengths and assets which will make you successful once you become employed. Your plan also includes a series of intermediate steps for you to attain, with the help of your vocational training specialist as you work toward your vocational goal which when completed, should mean that your are ready to obtain and retain a job.

CLIENT ACKNOWLEDGEMENT

I participated in the development of this plan. I established the employment goal and the goals contained in this plan, with the assistance of my vocational training specialist and my family members and support providers. I accept this plan and its contents and will participate in periodic reviews, updates and modifications as necessary so that I may accomplish my goal of obtaining employment. It is my responsibility to uphold my responsibilities outlined in this plan and to work with my vocational training specialist in a coordinated effort to achieve my goals and complete the program. My signature below indicates that I have received a copy of this plan.

Client Signature: _____ Date _____

Vocational Signature: _____ Date: _____

Referring Counselor/Case Manager Signature: _____ Date: _____

Supervisor Review Completed by: _____ Date: _____

ROLES AND RESPONSIBILITIES

VOCATIONAL SPECIALIST

Your Vocational Training Specialist will help you develop a plan of service that will help prepare you for employment through training, education, referral and work experience. Your progress in the program will be monitored weekly by your work site supervisor and reviewed with you monthly in a comprehensive report that will be shared with your referring case manager. Copies of the Monthly Report and this Individualized Training Plan will be given to you. Should your Vocational Training Specialist and /or other members of your team determine that the Work Adjustment Program cannot meet your needs, you will be referred to other resources that may be able to assist you.

YOU, THE PARTICIPANT

You will work with the Vocational Training Specialist to complete your training program by staying positive, working hard to meet your goals, following all program and safety rules, and communicating any questions or concerns to your Vocational Training Specialist as soon as possible.

REFERRING COUNSELOR/CASE MANAGER AND OTHER TEAM MEMBERS

As authorized by you in a signed release of information, your counselor or case manager and other team members will assist you in meeting the goals and outcomes outlined in this plan. They will receive copies of your monthly reports and will be invited to scheduled team meetings. Any concerns regarding your program participation will be addressed with you, your counselor/case manager and other team members.

STRENGTHS AND ASSETS FOR EMPLOYMENT

FUNCTIONAL LIMITATIONS THAT AFFECT OBTAINING OR MAINTAINING EMPLOYMENT

BARRIERS TO EMPLOYMENT/ JOB RETENTION

HEALTH & SAFETY CONCERNS

Based on the functional limitations noted above, the following potential **Health & Safety Concerns** have been identified:

HEALTH OR SAFETY RISK	ACTIONS TAKEN TO MINIMIZE RISK	INDIVIDUAL RESPONSIBLE

REASONABLE ACCOMMODATIONS REQUESTED

ASSISTIVE TECHNOLOGY NEEDS (If Applicable)

CULTURAL CONSIDERATIONS

EMPLOYMENT GOAL

Job Title: _____ Number of Hours per week: _____

Client agrees with this goal: _____ VTS agrees with the goal: _____ Counselor/Case Manager agrees: _____

INTERMEDIATE STEPS TOWARD EMPLOYMENT GOAL

(Use additional pages if necessary)

GOAL/OBJECTIVE	PERSON(S) RESPONSIBLE	TIME FRAME	REVIEW DATE	DATE ACHIEVED
1. _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
4 _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SUPPORT PROVIDERS AND/OR FAMILY ACKNOWLEDGEMENT

The following support providers and/or family members participated in the meeting to develop the plan and agree to assist in the implementation/completion of this plan by completing their responsibilities as outlined in the plan.

Name	Signature	Relationship	Date

PLAN REVIEW

The plan is reviewed every thirty days while client remains in Work Services

1st Review: _____

_____

2nd Review: _____

_____

3rd Review: _____

_____

4th Review: _____