Intake Plan Meeting Date:      

Intake Plan Start Time:

Intake Plan End Time:

Vendor Company Name:

Vendor Representative’s Name:      

VR Participant Name:      

VR Counselor Name:      

DVR Purchase Order #:      

Vocational Goal:

VR Counselor’s Referral question(s) or concerns:

VR Participant’s accommodation and/or Assistive Technology needs necessary for successful completion of the service objectives:

Legal Issues:

VWATS - Adult is needed to assist the VR Participant in achieving the core work readiness/employability skill objectives identified below by the following anticipated completion date:      

**1. SPECIFIC SERVICE OBJECTIVES**

*Using the Vocational and Work Adjustment Training Services Skills Appraisal Guide (Exhibit G1), in addition to clear and measurable terms, describe specific services needed for each core work readiness/employability skills objectives identified below for the VR Participant to obtain and maintain competitive employment. Please only complete the fields below for the core work readiness/employability objectives where training is necessary for the VR Participant (Starting Standard less than three (3)).*

**Mobility:**

Training Necessary  Yes  No

Starting Standard:      

Anticipated Number of Hours:

Details of Services Needed:

**Communication:**

Training Necessary  Yes  No

Starting Standard:      

Anticipated Number of Hours:

Details of Services Needed:

**Personal Care:**

Training Necessary  Yes  No

Starting Standard:      

Anticipated Number of Hours:

Details of Services Needed:

**Self-Direction**

Training Necessary  Yes  No

Starting Standard:

Anticipated Number of Hours:

Details of Services Needed:

**Interpersonal Skills:**

Training Necessary  Yes  No

Starting Standard:      

Anticipated Number of Hours:

Details of Services Needed:

**Work Tolerance:**

Training Necessary  Yes  No

Starting Standard:      

Anticipated Number of Hours:

Details of Services Needed:

**Work Skills:**

Training Necessary  Yes  No

Starting Standard:      

Anticipated Number of Hours:

Details of Services Needed:

**2. Job Readiness Training Work Site:**

Is it anticipated that a Job Readiness Training Work Site will be needed for the above core work readiness employability skill objectives?  Yes  No

Is this Placement Related to the VR Participant’s Vocational Goal?  Yes  No

Starting Date (MM/DD/YYYY):

Business Name:

Business Location/Address:

Business Position/Title:

Is this a Paid Training?  Yes  No

If a Paid Training, Rate of Pay:

Hours Per Week:

Tasks VR Participant will Experience/Learn:      Additional Comments, if applicable:

**2. OUTCOME OF THE SERVICE PLANNING MEETING**

Check one (1):

Vendor accepts referral and agrees to begin services within ten (10) business days from the Intake Plan meeting

Vendor or VR Participant declines referral. Explain why:      

VR Participant or VR Counselor was a “no-show” for Intake Plan meeting

Revised Intake Plan. Date Revised:

If unable to start service within ten (10) business days, please explain why:

VR Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

VR Participant Guardian/Representative Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Other (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Vendor Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

VR Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: