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: