

Service Plan

A

Case Information

Affiliates should use the *Service Plan* to assess clients' needs and create a self-sufficiency plan that is centered on working towards clients' employment and/or self-sufficiency. The *Service Plan* must be completed within 30 days of clients' arrival and should be updated throughout their R&P period.

PA Name:		Case Number:	
Address:		Arrival Date:	
Phone Number:		30th Day:	
E-mail:		90th Day:	

If enrolled in Matching Grant (MG)

MG Eligibility Date: <i>*(If CHEP, Asylee, VoT, non-R&P SIV or Amerasian with eligibility after 31st day or before 90th day only: Use MG Enrollment Date as Eligibility Date)</i>		# Enrolled:		120th Day:	
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MG Enrollment Date:		# of Employables:		180th Day:	
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Monthly Income Needed to be Self-Sufficient <i>(amount noted on the MG Pre-Employment Budget):</i>	
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	Name: (List PA first)	Relationship to Principal Applicant (PA):	Date of Birth:	Alien Number:	Social Security Number:	Employable: Y/N	Enrolled in MG: Y/N	Minor Code: (M2-M7)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Service Plan

B

Needs Assessment for Employable Client

This form should be completed for each employable client in the case (*copy the tab/page for each adult client who is employable*). Please provide follow-up in Section D: Family and Individual Self-Sufficiency Plan

Client Name:	Assessment Date:
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I. LANGUAGE AND LITERACY SKILLS

What is your primary language? (<i>specify language</i>)	
Do you speak any other languages? (<i>specify language/s</i>)	
What languages can you read or write? (<i>specify language/s</i>)	
English language level (None/Basic/Intermediate/Advanced)	
English language training needed (Y/N)	

II. HEALTH STATUS	Y	N	Comments
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Are you able to stand, bend, lift and have full use of your hands?			
Do you have any vision problems?			
Do you have any hearing problems?			
Do you have any other physical impairments that may affect your employment?			
Are you on medication that may limit your employment?			
Do you have any medical/mental health needs that need to be addressed? (<i>ex. Are you sleeping well? Do you feel anxious? Do you feel safe?</i>)			

III. CHILDCARE	Y	N	N/A	Comments
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If client(s) has a child(ren) under one, there is a person designated for care				
If client has a child(ren) between the ages of 1 - 4, they have adequate daycare				
If client has child(ren) who are in school (kindergarten to 14 years old), they have after-school care				

IV. EDUCATION

Name of School/University/Other	From	To	City/Country	Degree/Certificate/Qualification

V. WORK HISTORY (*Write N/A in section below if client has no work history*)

Job/Trade/Company	From	To	City/Country	Position & Responsibilities

VI. JOB AVAILABILITY

Are you currently seeking employment?	
If seeking employment, do you have any restrictions on the hours/days you can work? (<i>specify restrictions</i>)	
If seeking employment, do you have any religious restrictions that limit the kind of work you are willing and able to do? (<i>specify restrictions</i>)	
If seeking employment, are there any other issues or concerns that might limit the work you can do?	

VII. PROFESSIONAL GOALS

If seeking employment, what type of job are you interested in pursuing this year?	
What type of job/career do you hope to have in five years?	
What other skills and experience do you have that will help you pursue these short and long-term goals?	
If seeking employment, what will you do to look for a job yourself? (<i>optional</i>)	

Service Plan



Needs Assessment for Non-Employable Client

This form should be completed for each non-employable client in the case (*copy the tab/page for each adult client who is employable*). Please provide follow-up in Section D: Family and Individual Self-Sufficiency Plan

Client Name:		Assessment Date:	
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Reason(s) client is not employable:

Physical / Mental Health Reasons	Caregiver for a child under one	Caregiver for a fully dependent person	65 years or older on arrival	Late stage pregnancy	Under 18 years old on arrival	Other (<i>include comment</i>)

*Reasons above are based on PRM's Program Announcement 2013-08 Attachment A. Please ensure that case files include supporting documentation and explanation as to why client is exempt from employment.

I. LANGUAGE AND LITERACY SKILLS

What is your primary language? (<i>specify language</i>)	
Do you speak any other languages? (<i>specify language/s</i>)	
What languages can you read or write? (<i>specify language/s</i>)	
English language level (None/Basic/Intermediate/Advanced)	
English language training needed (Y/N)	

II. HEALTH STATUS

	Y	N	Comments
Do you have any vision problems?			
Do you have any hearing problems?			
Are you on medication that may interfere with your daily activities?			
Do you have any medical/mental health needs that need to be addressed? (<i>ex. Are you sleeping well? Do you feel anxious? Do you feel safe?</i>)			

III. EDUCATION

Highest level of education (<i>please specify</i>)	
Education follow-up needed (Y/N)	

IV. GOALS (*identify goals with client for the first year in the U.S.*)

Plan to achieve goal

1)	
2)	
3)	

Service Plan

D

Family Needs Assessment and Self-Sufficiency Plan

The Family Needs Assessment should be completed with the client(s) to identify their strengths and needs that will need follow-up throughout the R&P and MG periods. This assessment should be referred to throughout the program(s) period to ensure all the clients' immediate needs were addressed.

PA Name:	Case Number:
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Area to Assess:	Strength(s):	Need(s): <i>(Add to Goal section below)</i>
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Basic Needs <i>(ex. Housing, Food, Clothing)</i>		
Health		
Employment		
Financial Literacy		
Transportation		
Childcare		
Life Skills <i>(ex. English classes)</i>		
Other <i>(specify)</i>		

Discuss with the client(s) the goals and action steps to achieve self-sufficiency (short and long-term goals may be included). Goals and action steps should be based on the strengths and needs identified in all parts of the Service Plan and should focus on the unique needs of the clients rather than core services that apply to all clients. Affiliates are encouraged to review the self-sufficiency plan with client(s) regularly during their R&P and MG periods.

Client(s):	Goal:	Action Steps:	Target Date:	Completed Date:	Person Responsible for Follow-Up:

Comments:

Signatures:

Date:

Client Name:

Client Signature:

Client Name:

Client Signature:

Client Name:

Client Signature:

Staff Member Name:

Staff Member Signature:

Interpreter Name:

Interpreter Signature: