Effective January 23, 2012, an Individual Service Strategy format consisting of four phases: an Assessment, Work Strategy, Training Plan and 12 Month Post Exit Follow-Up will be used for all WIA Adult and Dislocated Worker participants. The Assessment, Work Strategy, and the bolded portion of the Training Plan must be completed during the Assessment and prior to the case being presented for approval. The Training Plan will be completed when the decision has been made whether or not to enroll the client. The Post Exit Follow-Up Plan will be completed towards at the end of the training (at least 30 days prior to completion) to establish the necessary follow-up assistance for the 12 month period. This will replace the need to complete the Employability Plan found in DJL. Case managers may add items to this document but the items contained here must be completed and are the minimum elements to be included.

**Individual ISS’s should be created as a Word document. A completed copy of the ISS should be kept in the participant file. Any planned contacts and updates to the ISS should be notated in the Program Detail Notes.**

In all cases:

* Individual Service Strategies will be jointly developed with the client.
* Client will sign and receive a copy of the ISS after the case has been approved by the supervisor.
* Plan will be updated as needed.

ISS Attached

# \_\_\_\_\_\_\_\_

CM Initials

# Individual Service Strategy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Date of Assessment

**Acknowledgement Statement:**

**The purpose of this assessment is to help DOL case managers assess if you (the client) are in the best possible situation to achieve your training and employment goals. If you do not feel comfortable sharing any of the information being requested, please feel free to say no.**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## ASSESSMENT

**NAME:**

Last First Middle

**ADDRESS:**

Street Apt. # Route #

City State Zip Code

|  |
| --- |
| **Directions to home:** |

**PHONE:**  (Day) (Evening)

**CELL PHONE:** **E-MAIL:**

Alternate Contacts: Relative (Name/Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Friend (Name/Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEST TIME TO CALL:** **AM or PM Timeframe** (*ex. 12pm to 4pm*)

**PID:** **DOB:**

* Household Information - **Please list all household members**
* **PLEASE NOTE: Household Information is not to be used when determining Eligibility. This is not the Definition for Family – please refer to Policy 4 for Definition of Family**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **age** | **Grade** | **Sex** | **Relationship** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Notes:**

.

* Outside Supportive Services

TANF Check:  Yes  No

Food Stamps:  Yes  No

Child Care:  Yes  No

Medicaid:  Yes  No

Other:

Are you a parent or guardian of a child receiving SSI: [ ] Yes [ ] No

Are you currently receiving case management services from any other entity? [ ] Yes [ ] No

If yes, please check and complete below:

[ ] Housing [ ] DSS [ ] Voc Rehab [ ] Veteran

Other:

*Dual Case Manager(s) Information:*

Name:

Phone:

Organization:

**Notes:**

.

PRIMARY AREAS OF CONCERN

#### Medical/Mental Assessment (It’s the case manager’s discretion to ask Questions 1 & 2. If not answered case manager must provide a justification as to why the questions were not asked.)

1.Are you interested in obtaining information regarding domestic violence in your home?

[ ] Yes [ ] No

If yes please explain:

2.Are you interested in obtaining information or in need of a referral for a mental health, alcohol or substance abuse problem? [ ] Yes [ ] No

If yes, are you currently undergoing treatment? [ ] Yes [ ] No

Describe any concerns:

3.Are you in need of an accommodation to assist you with any physical, emotional, or medical impairment that could interfere with your performance in training or a job? (i.e. Insulin for Diabetes, High Blood Pressure, etc…)

[ ] Yes [ ] No

If yes, please explain.

#### Education

[ ] Less than high school Grade completed

[ ] High school graduate/GED Year completed

[ ] Some College Area of Study

[ ] College Graduate Degree/Major

[ ] Trade school Area of training

Are you currently in school? [ ] Yes [ ] No

If yes, what school are you attending?

□ Community College □ Adult Vocational Technical School □ DOL/DEDO Training

Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ 4-yr post secondary institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received training funds through the Department of Labor: [ ] Yes [ ] No

If yes, who is/was your worker?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your anticipated date of completion and/or graduation?

If no, are you interested in going to school for:

A GED Program? [ ] Yes [ ] No

Vocational Training? [ ] Yes [ ] No

Other Schooling? [ ] Yes [ ] No

**Notes:**

* + Housing

### Please check appropriate spaces: Yes No

I have my own home (rent/purchase). \_\_\_\_\_\_ \_\_\_\_\_\_

I live with relatives and/or friends.

I am homeless and in need of housing

I am living in public/subsidized/section-8 housing.

If living in public/subsidized/section-8 housing:

Where? How long have you been there?

Date of last certification: How often do you recertify?

If you are in need of housing:

Are you currently living in a shelter, motel or transitional housing? [ ] Yes [ ] No

If yes, name of place staying:

How long have you been there?

How long can you stay?

Are you currently on a housing waiting list? [ ] Yes [ ] No

If yes, where: For how long?

Have you ever been evicted? [ ] Yes [ ] No

If so, when and for what reason:

**Notes:**

#### Transportation

### Please check appropriate spaces: Yes No

I have a valid driver’s license.

If no, has your license been suspended or revoked? [ ] Yes or [ ] No

If yes, when will you be eligible?

Are there any requirements that you have to meet? [ ] Yes or [ ] No

If yes, please explain:

I have my own car.

I have the use of another reliable car.

I have a Dart bus stop nearby.

I am currently using DART MTW System.

(MTW= Moving to Work program)

Have you been convicted of a moving traffic violation within the last 3 years? [ ] Yes or [ ] No

How many points do you currently have?

I will use the following transportation to get to and from work/schoool:

My back-up transportation is:

**Notes:**

* + Child Care/Elderly Care – Please complete if you have a household member 18 years or younger or if your caring for an elderly person

### Please check appropriate spaces: Yes No

I am in need of a child/elderly care provider.

I am in need of a flexible child/elderly care provider.

I have a regular child/elderly care provider.

□ Care Center □ Home Care □ Family Member □ Friend

Name of provider:

I have a back-up child/elderly care provider.

□ Care Center □ Home Care □ Family Member □ Friend

My back-up provider is .

In the case of the following events, who would be your back-up provider?

1. Illness for yourself or your dependent:

2. School closure:

3. Summer break:

If you have school age children, are they currently in an Afterschool Program:

[ ] Yes [ ] No

If yes, Name of Afterschool Provider:

Are you currently receiving Purchase of Care? [ ] Yes [ ] No

If so, do you have a co-pay? [ ] Yes [ ] No If yes, how much:

**Notes:**

#### Legal Issues

Have you ever been convicted of a misdemeanor? [ ] Yes or [ ] No

If yes, when: Please explain:

Have you ever been convicted of a felony? [ ] Yes [ ] No

If yes, when: Please explain:

If you answered yes to the above, are you currently on probation? [ ] Yes [ ] No

If yes, what level? For how long?

Who is your Probation Officer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**POTENTIONAL SUPPORTIVE NEEDS**

* Clothing/Uniform □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dental □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Nutritional □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Social

How would you rate your credit?

[ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Unsure

**Notes:**

# **MONTHLY BUDGETING WORKSHEET**

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **INCOME** | **Monthly Amount** | **Comments** |
| Wages (Take home) |  |  |
| Wages (Take home) |  |  |
| TANF |  |  |
| Food Stamps |  |  |
| Child Support |  |  |
| SSI |  |  |
| Other |  |  |
| TOTAL: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **EXPENSES** | | **Monthly Amt.** | Comments |
| Housing  35% | Mortgage/Rent/Lot Rent |  |  |
| Insurance (Renters/Home Owners) |  |  |
| Electric |  |  |
| Fuel Oil/Gas |  | □ Qtly\_\_\_\_\_\_ □ \_\_\_Month(s) \_\_\_\_ |
| Water/Sewer |  | □ Qtly\_\_\_\_\_\_ □ \_\_\_Month(s) \_\_\_\_ |
| Telephone |  |  |
| Cell Phone/Pager |  |  |
| **Sub-total:** |  |  |
| Transport.  20% | Car Payments |  | □ Weekly □ Biweekly □ Monthly |
| Car Insurance |  | □ Qtly\_\_\_\_\_\_ □ \_\_\_Month(s) \_\_\_\_ |
| Maintenance (Gas/Oil) |  |  |
| Public Transportation |  |  |
| **Sub-total:** |  |  |
| Other Debts – 15% | Credit Card |  |  |
| Furniture Bill |  |  |
| Other – Loans/Fines/Child Support |  |  |
| **Sub-total:** |  |  |
| All Other Expenses  20% | Groceries |  | FS Grant Amt:\_\_\_\_\_\_ Extra:\_\_\_\_\_\_ |
| Clothing/Personal Care |  |  |
| Medical (Dental Bills) |  |  |
| Entertainment (Video Rental/Cable) |  |  |
| Gifts/Donations/Tithes |  |  |
| Child Care (Refer to page 4) |  |  |
| Miscellaneous Expenses (Life Ins.) |  |  |
| **Sub-total:** |  |  |
| **TOTAL EXPENSES:** | |  |  |

|  |  |  |
| --- | --- | --- |
| ***Total Income (-)*** | ***Total Monthly Expenses*** | ***= Difference*** |
|  |  |  |

If monthly expenses are more than total income, is it addressed in Service Plan? Yes or No

*If not, why?*

Have you completed a financial literacy program within the last year? Yes or No

*If yes, When*: *and by whom*:

**Work Strategy**

On your current or past jobs have you ever been verbally warned or written up for:

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** |  |
|  |  | Tardiness (Late for Work) |
|  |  | Unexcused absences (no call/no show) |
|  |  | Insubordination |
|  |  | Failure to meet productivity standards |
|  |  | Poor attendance |

How many jobs have you held within the last (6) months?

1 2 3 4 5 5 or more

Are you a veteran? [ ] Yes [ ] No

If yes, type of discharge:

Do you have a resume? [ ] Yes [ ] No

Do you volunteer for your church or community? [ ] Yes [ ] No

If so, please list where and what you do:

Please list any additional skills or abilities that may assist you in obtaining employment. (Example: supervised 5 people, type 45 wpm, etc.)

Employment Interest:

Dream Job: Entry-Career Job:

How many miles are you willing to travel (one way)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to do shift work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, would shift work require family accommodations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you working 30 hours or more? Yes or No

Does customer have a sporadic work history (ex: 3 or more job within a year)?  Yes  No

***TRAINING PLAN***

**Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Training Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Training End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time(s) of Training Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Training Plan should include responsibilities of the case manager and participant, items to be accomplished, scheduled review dates & timeframes for completion.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Steps to Employment | Description of the Planned Level of Contact (Intensity & Duration) | Accountability for the Step | Planned Accomplishment Date of the Step | Actual Accomplishment Date of the Step |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Rationale/Progress

|  |  |  |
| --- | --- | --- |
| Comments (who, what , when, where, why and how) | Staff Initials/Date | Client Initials/Date (if necessary) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***Post Exit Follow-Up Plan***

9. Post Participation Plan - Describe the plan for Follow-up services to be provided. This section should describe both the activities used and any transition in the types and intensity of services (Participant initial date preferred but not required)

|  |  |  |
| --- | --- | --- |
| Activities, Duration & Intensity | Staff initial/date | Participant initial/date |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

10. Post Participation Plan Justification – Explain why the follow-up activities were chosen and what behaviors the services are expected to impact. (Participant initial date preferred but not required)

|  |  |  |
| --- | --- | --- |
| Justification | Staff initial/date | Participant initial/date |
|  |  |  |

Emergency Contact Information:

Name Relationship Phone

*I acknowledge that the following occurred:*

* + - Individual Service Strategy (ISS) was just completed.
    - I have been informed of the frequency of contact obligation to my DOL case manager.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Customer Signature Date Supervisor Signature Date**