



SELF-SUFFICIENCY PLAN FOR IMPACT CLIENT

State Form 47194 (R4 / 4-09) / IMP 0007

		Date of next review <i>(month, day, year)</i>
Name of client	Social Security number	Date <i>(month, day, year)</i>
Name of IMPACT case manager	Telephone number ()	Case number

Employment goal:
Personal goal:

Strengths:

Barriers:

Activity	Referral to or Responsibility for	Purpose	Assignment Date <i>(month, day, year)</i>	Completion Date <i>(month, day, year)</i>	Participation Hours

By signing this plan for employment, I agree to the goals, strengths, barriers, and activities listed above. I also agree that I will seek and retain employment. I understand that if I need support services such as childcare, clothing, transportation expenses, or vehicle expenses, I should contact the IMPACT Case Manager. I understand my rights and responsibilities under the IMPACT Program. I understand conciliation procedure should I disagree with this plan. I understand compliance with this plan and the penalties for not participating in the program.			
Signature of client	Date <i>(month, day, year)</i>	Signature of IMPACT staff	Date <i>(month, day, year)</i>