Individualized Plan for Employment
Department for the Blind and Vision Impaired

Participant _____ **Participant ID** _____

Caseload _____

1. Services Description

Plan Number _____

Service Category _____

Procedure Description _____

Description

_____

_____

_____

_____

_____

Estimated Start Date _____

Estimated End Date _____

Estimated End Date or Event _____

My Chosen Provider _____

2. Estimated Service Costs

Participant	$_____
Others/Comparable Benefit	$_____
Agency	$_____
Source to be Determined	$_____
Total Service	**$**_____

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Participant _____ **Participant ID** _____

Caseload _____

Source of Comparable Benefits Checkbox List

_____ Employer medical Insurance
_____ JTPA
_____ Medicare
_____ Other
_____ Pending Litigation
_____ VA Grant
_____ Worker's Compensation
_____ Family
_____ Medicaid
_____ None
_____ PELL Grant
_____ Private Insurance
_____ VA Medical

3. Service Completion

Actual End Date _____

4. Comments

_____

_____

_____

_____

_____