SELF-SUFFICIENCY PLAN FOR IMPACT CLIENT

State Form 47194 (R2 / 12-02) / IMP 0007

Date of next review (*month, day, year*)

Name of client	Social Security number	Date (*month, day, year*)
Name of Family Case Coordinator	Telephone number ( )	Case number

Employment goal:
Personal goal:

Strengths:	Barriers:

Activity	Referral to or Responsibility for	Purpose	Assignment Date	Completion Date	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, vehicle expenses I should contact my Family Case Coordinator. I understand my rights and responsibilities to 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 (*month, day, year*)	Signature of IMPACT staff	Date (*month, day, year*)

DISTRIBUTION: White - Case File; Canary - Client