



Name: _____ TABS ID #: _____

VOCATIONAL DEVELOPMENT PLAN

PURPOSE: To consolidate information gathered during Discovery and create a plan for the next steps to assist the individual to build independence and develop employment skills. The plan is meant to be shared with the individual's current and future supports. This information should highlight the positive attributes and describe specific vocational challenges identified during Discovery.

INSTRUCTIONS: Fill out each section below and submit the plan to the ETP Supervisor for review. With input from the ETP Supervisor, a meeting may be held to discuss the plan and next steps with the individual and their Circle of Support. Information in the chart on page 3 should be clearly stated so that the individual, their family, their Care Manager, and any support staff working with them are able to monitor their progress as they work to improve in the noted challenge areas.



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The following services are being recommended:

- | | | |
|---|--|--|
| ☐ Community Habilitation | ☐ Community Pre-Voc | ☐ Pathway to Employment |
| ☐ Day Habilitation | ☐ Recreation | ☐ Other (list below): |

Summarize the positive attributes observed during Discovery:

Summarize the reason(s) that Job Development is not being recommended at this time:

Check off the challenge areas that were identified during Discovery:

- | | |
|---|---|
| ☐ General Workplace Independence | ☐ Physical / Medical / Mental Health |
| ☐ Stress Management | ☐ Communication |
| ☐ Social Interactions / Relationships | ☐ Focus /Attention to Task |
| ☐ Productivity / Work Pace | ☐ Safety / Environmental Awareness |
| ☐ Transportation Resources | ☐ Personal Grooming / Hygiene |
| ☐ Attendance / Punctuality / Time Management | ☐ Initiative / Motivation to Work |
| ☐ Other (specify): _____ | |



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Instructions: SEMP Staff / Manager should complete as much of this information as possible prior to ETP Supervisor review.

1. Identified challenge area: _____

Service/Activity Recommended: _____

2. Identified challenge area: _____

Service/Activity Recommended: _____

3. Identified challenge area: _____

Service/Activity Recommended: _____

4. Identified challenge area: _____

Service/Activity Recommended: _____

5. Identified challenge area: _____

Service/Activity Recommended: _____

ATTACH ADDITIONAL INFORMATION IF NEEDED

Plan completed by:

Name: _____ Title: _____

Signature: _____

Agency: _____ Date: _____



Name: _____ TABS ID #: _____

PLANNING MEETING SUMMARY

To be completed by Circle of Support Meeting facilitator

Date of meeting: _____

Please list the attendees names and their relationship to the individual:

- | | |
|----------------|---------------------|
| 1. Name: _____ | Relationship: _____ |
| 2. Name: _____ | Relationship: _____ |
| 3. Name: _____ | Relationship: _____ |
| 4. Name: _____ | Relationship: _____ |
| 5. Name: _____ | Relationship: _____ |
| 6. Name: _____ | Relationship: _____ |
| 7. Name: _____ | Relationship: _____ |
| 8. Name: _____ | Relationship: _____ |
| 9. Name: _____ | Relationship: _____ |

Summary of meeting:

Signature: _____

Title: _____ Date: _____

cc: Individual, Care Manager, Support Staff, Other