

WISCONSIN WORKS (W-2) EMPLOYABILITY PLAN

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]

PARTICIPANT:	SSN:	PIN:	
PRINTED ON (DATE):		OFFICE:	WORKER:

PART 1 - PARTICIPANT EMPLOYMENT AND RELATED GOALS

JOB GOALS DURING PROGRAM PARTICIPATION:		
	JOB TITLE	JOB (DOT) CODE
PRIMARY:	_____	_____
SECONDARY:	_____	_____
ADDITIONAL:	_____	_____
RELATED GOALS NOT REQUIRED FOR PROGRAM PARTICIPATION:		
LONG-TERM:	_____	
SHORT-TERM:	_____	

PART 2 - PARTICIPANT PERSONAL GOALS (NOT REQUIRED FOR PROGRAM PARTICIPATION)

	PLANNED COMPLETION DATE
1. _____	___/___/___
2. _____	___/___/___
3. _____	___/___/___
4. _____	___/___/___
5. _____	___/___/___
6. _____	___/___/___

PART 3 - PARTICIPANT PROGRAM ACTIVITY PLAN (REQUIRED FOR PROGRAM PARTICIPATION)

The participant program activity will begin on ___/___/___ and will be reviewed on ___/___/___. During this time the W-2 placement is a _____. All W-2 payments may end if a new employability plan is not completed by the review date.

The participant program activity plan will help you meet your goal to get a job. It lists the activities that will assist you in getting a job. Your worker will meet with you to talk about your progress and make changes to your plan, if needed.

ACTIVITY 1: _____	HOURS PER WEEK: _____
PLANNED BEGIN AND END DATES: ___/___/___ TO ___/___/___	
PROVIDER OF SERVICE: _____	
LOCATION: _____	
SUPPORTIVE SERVICES: CHILD CARE _____ TRANSPORTATION _____	
REMARKS: _____	

RETAIN COMPLETED FORM IN CASE RECORD

OVER

ACTIVITY 2: _____ HOURS PER WEEK: _____
 PLANNED BEGIN AND END DATES: ___/___/___ TO ___/___/___
 PROVIDER OF SERVICE: _____
 LOCATION: _____
 SUPPORTIVE SERVICES: CHILD CARE _____ TRANSPORTATION _____
 REMARKS: _____

ACTIVITY 3: _____ HOURS PER WEEK: _____
 PLANNED BEGIN AND END DATES: ___/___/___ TO ___/___/___
 PROVIDER OF SERVICE: _____
 LOCATION: _____
 SUPPORTIVE SERVICES: CHILD CARE _____ TRANSPORTATION _____
 REMARKS: _____

ACTIVITY 4: _____ HOURS PER WEEK: _____
 PLANNED BEGIN AND END DATES: ___/___/___ TO ___/___/___
 PROVIDER OF SERVICE: _____
 LOCATION: _____
 SUPPORTIVE SERVICES: CHILD CARE _____ TRANSPORTATION _____
 REMARKS: _____

ACTIVITY 5: _____ HOURS PER WEEK: _____
 PLANNED BEGIN AND END DATES: ___/___/___ TO ___/___/___
 PROVIDER OF SERVICE: _____
 LOCATION: _____
 SUPPORTIVE SERVICES: CHILD CARE _____ TRANSPORTATION _____
 REMARKS: _____

I have agreed that I will do the activities listed in this Employability Plan. I know that I must do these activities to receive my W-2 payments which include child care and transportation. I know if I don't do these activities, (including keeping all appointments, completing up-front job search, accepting a job, and keeping a job), my W-2 payment may be denied, ended, or reduced \$5.00 for each hour I miss. I will contact my worker if I cannot go to my assigned activities.

SIGNATURE OF THE PARTICIPANT	DATE SIGNED
I have provided an explanation of the conditions and requirements for the activities listed, the W-2 participation time limits, and have provided the opportunity to answer the participant's questions.	
SIGNATURE OF W-2 WORKER	DATE SIGNED

COMMENTS:
