



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

14 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-0759
FAX: (401) 462-3204

My Career Development Plan

Name:	DOB:	Age:	Meeting Date(s):

My Career Goal:

I, a family member and/ or rep payee on my behalf, have received information on Social Security Work Incentives? Name: _____ Date: _____	<input type="checkbox"/> No Information Received	<input type="checkbox"/> Medicaid Pathways to Health Coverage for Working Adults with DD
	<input type="checkbox"/> Work Incentives Myths and Facts or FAQ <input type="checkbox"/> SSA Working While Disabled Pamphlet <input type="checkbox"/> Sherlock Plan Brochure/fact sheet	<input type="checkbox"/> Attended a Group Work Incentive information Session <input type="checkbox"/> Attended an individual counseling session with a CWIC

I have a benefits plan written by a Certified Work Incentives Counselor (CWIC)?	Yes _____ No _____ Comment: _____	Date: _____
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My Career Development Team: (Persons assisting me with the development of this plan)

Name _____ Title _____
Individual

Name _____ Title _____
Parent/Guardian

Name _____ Title _____
Provider Agency/Plan Writer

Name _____ Title _____
BHDDH Representative

Name _____ Title _____
ORS

Name _____ Title _____
Other

Name _____ Title _____
Other

My Assessments (Include Vocational Assessment & Person Centered Planning)	
Method/Tool:	Date(s):

My Interests & Preferences	
My Expressed Area of Interest	
My Job Preferences	
Recommendations from my Career Development Team	

My Preparatory Experiences		
Experience	Tool or Method	Date
Social Skills Training		
Career Exploration		
Soft Skill Development		
Job Skill Development		
Leadership Development		
Educational & Community Services		
Self-Advocacy/ Self-Determination		
Conflict Resolution		
Peer & Adult Mentorship		
Daily Living Skills		
Assistive Technology		
Other:		

Information below is based upon results of My Assessments, Person Centered Planning, School Based Preparatory Experiences (get school transcript if available), Vocational & Related Services, and Integrated Trial Work Experiences and/or Current Employment:

My Employment Strengths			
My Employment Barriers			
Attain Career Goal Services & Supports Needed		Persons Responsible:	Date:
Job Retention/Career Advancement Services & Supports Needed		Persons Responsible:	Date:

Accommodations Needed (Including Assistive Technology):

Person/Agency Responsible:

Transportation:

How will or do I get to and From work? (Check all that apply)

RIPTA		Family	
Paratransit (RIDE)		Friends/co-worker	
Agency		Walk	
Driver's License/Car		Other (describe)	

Type of Support Needed: (Check all that apply)		
	Need	Person or Agency Responsible
Independent		
Needs Training: (i.e. Travel & pedestrian safety, reading bus schedule)		
Needs Assistance to Access		
No Access to Transportation		

Update and Signature Page			
Date	Area updated	Name	Signature

Additional comments and/or follow up plans:

***Please include a Release of Information for BHDDH and/or ORS as part of the Career Development Plan.