SNA-1005A FORFF (3-23)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Employment Administration ● Supplemental Nutrition Assistance Employment and Training (SNA E&T) Program

EMPLOYMENT AND CAREER DEVELOPMENT PLAN (ECDP)

Participant's Name *(Last, First, M.I.)* _____ Phone No. and Area Code. _____

Initial ECDP Date _____ ECDP Revision Date _____ Participant's Email Address _____

Short-Term Employment Goal _____

Career Goal _____

ACTIVITY / ACTIVITIES

ACTIVITY	PROVIDER NAME / LOCATION	BEGINNING DATE	ENDING DATE	ENTER HOURS SCHEDULED PER DAY							
				SAT	SUN	MON	TUES	WED	THURS	FRI	TOTALS
				SAT	SUN	MON	TUES	WED	THURS	FRI	TOTALS
				SAT	SUN	MON	TUES	WED	THURS	FRI	TOTALS
				SAT	SUN	MON	TUES	WED	THURS	FRI	TOTALS
				SAT	SUN	MON	TUES	WED	THURS	FRI	TOTALS

SUPPORT SERVICES

SUPPORT SERVICE	PROVIDER NAME / LOCATION	BEGINNING DATE	ENDING DATE	PURPOSE OF REFERRAL

Comments *(If applicable, describe the needs of other family members that may be addressed through the SNA E&T Program)*

If needed, did you refer participant to services outside of E&T ☐ Yes ☐ Not applicable

Does the client have a child/dependent aged 5 or under? ☐ Yes ☐ Not applicable

If needed, did you refer the participant to a Head Start location? ☐ Yes ☐ Not applicable

STATEMENT OF UNDERSTANDING

I understand that the ECDP is required for participation in the SNA E&T Program. This ECDP was developed by a SNA E&T Specialist and myself and contains activities and services that we agree will help me become self-sufficient. I know that this ECDP is not a contract. I understand that it can be changed if my situation changes or if the SNA E&T Program resources change. I will notify SNA E&T staff if I want to change this plan. My signature below indicates that I understand this ECDP.

SNA E&T Participant's Signature _____ Date _____

SNA E&T Specialist's Signature _____ Date _____

See reverse for EOE/ADA disclosures