

Refugee Support Services Self-Sufficiency and Employability Plan

- a. Service Provider: _____
- b. Case Manager: _____
- c. Date of SSP: _____
- d. Date of EP: _____

Section One: Household Information
(Attach additional Applicant Information sections for household members if needed)

Name (Last, First, Middle): _____ Date of Birth (MM/DD/YYYY): _____

Date of ORR Eligibility (MM/DD/YYYY): _____ Date of Arizona Arrival (MM/DD/YYYY): _____

Local Resettlement Agency/Private Sponsorship Group: _____

Alien Number: _____ Social Security Number: _____ DES Case Number: _____

Gender Identity: Male Female Other Country of Origin: _____

ARRPODS Account? Yes No Program Enrollment Date: _____

Physical Address (Number, Street): _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (if different from physical address): _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Preferred method of contact: Email Phone Text Message Other: _____

Immigration Status:	Amerasian	Asylee	Cuban/Haitian Entrant	Victim of Human Trafficking
	Refugee	SIV	UHP	US Born Citizen

Marital Status:	Married	Separated	Divorced	Widowed
	Domestic Partners		Common Law	Cohabiting Couple

Do you have dependents? Yes No

Primary spoken language: _____ Other spoken languages: _____

Languages able to read and write: _____

Do you need interpretation services or translation of documents? Yes No

Additional Household Information

Public Benefit Assistance (Check all that apply)

TANF

RCA

Matching Grant Program

Former Matching Grant Program

SSI

No Cash

AHCCCS

RMA

SNAP

WIC

Worker's Compensation

Other: _____

If you receive any of the above listed types of public benefit, please answer the following questions:

What is the total amount you receive per month? _____

How long have you been receiving benefits? _____

If you are not receiving any of these benefits, please answer the following questions:

Have you previously received any of the listed benefits? _____

If No, are you interested in receiving benefits for which you are eligible? _____

Household Income

Income source, if any: _____ Monthly amount: _____

Health Insurance

Medicaid coverage: Yes No If 'Yes', what is your current plan?

Employer coverage: Yes No If 'Yes', what type of coverage and cost of the plan?

Coverage for dependents: Yes No If 'Yes', what type of coverage and cost of the plan?

Household Budget

Income: Yes No

If 'Yes', please describe Type: _____ Monthly amount: _____

Housing Type: Permanent Temporary

Housing Budget Type: Rent Mortgage Other: _____

Are you sharing household expenses? Yes No If 'Yes', please list the type of expenses you share.

Utility Type:

Housing: _____

Monthly amount: _____

Is the client experiencing any immediate issues with housing? Yes No

If 'Yes', please explain:

Electric: _____

Monthly amount: _____

Is the client experiencing any immediate issues with electric? Yes No

If 'Yes', please explain:

Gas: _____

Monthly amount: _____

Is the client experiencing any immediate issues with gas? Yes No

If 'Yes', please explain:

Water: _____

Monthly amount: _____

Is the client experiencing any immediate issues with water? Yes No

If 'Yes', please explain:

Phone: _____

Monthly amount: _____

Is the client experiencing any immediate issues with phone? Yes No

If 'Yes', please explain:

Other: _____

Monthly amount: _____

Is the client experiencing any immediate issues with other? Yes No

If 'Yes', please explain:

Food: _____

Monthly amount: _____

Is the client experiencing any immediate issues with food? Yes No

If 'Yes', please explain:

Clothing: _____

Monthly amount: _____

Is the client experiencing any immediate issues with food? Yes No

If 'Yes', please explain:

Personal Items: _____ Monthly amount: _____
Is the client experiencing any immediate issues with personal items? Yes No If 'Yes', please explain:

Child Care: _____ Monthly amount: _____
Is the client experiencing any immediate issues with child care? Yes No If 'Yes', please explain:

Transportation: _____ Monthly amount: _____
Is the client experiencing any immediate issues with transportation? Yes No If 'Yes', please explain:

IOM Travel Loan: _____ Monthly amount: _____
Is the client experiencing any immediate issues with IOM Travel Loan? Yes No If 'Yes', please explain:

Other Expenses: _____ Monthly amount: _____
Is the client experiencing any immediate issues with other expenses? Yes No If 'Yes', please explain:

Notes and Considerations - *Please note any household immediate needs for support.*

Household Member Self-Sufficiency Assessment: Minor Household Members

School Enrollment

Is the child currently enrolled in an educational institution? Yes No

If yes, what type of educational institution (e.g. *Public, Private, Residential*)? _____

What Grade-Level? Early Childhood Development (0-3) Pre-K K
 1 2 3 4 5 6 7 8 9 10 11 12 12+

If the child is within child care age, are they receiving child care services? Yes No

If 'No', do you need assistance with finding child care services? Yes No

Does the child have any additional support needs? Yes No

Does the child participate in any extracurricular activities? Yes No

If yes, what type of activities? _____

Does the child currently need assistance with any higher education or skilled training programs? Yes No

If 'Yes', what assistance do you need? _____

English Language Proficiency

Spoken English language proficiency: Very Well Well Not Well Not At All
 N/A individual under 16 years old Unable to provide information

Primary spoken language: _____

Other spoken languages: _____

Languages minor child is able to read and write: _____

Do you need interpretation services or translation of documents for the child? Yes No

Is the child in need of any additional tutoring/support with schooling? Yes No

If 'Yes', what subjects or topics do you need tutoring? _____

Employment

Is the minor over the age of 16 years? Yes No

If 'Yes', are they currently employed or seeking employment? Yes No

Section Two: Self-Sufficiency Plan and Goals

(Please use this template for all household members)

Use this form to develop employability goals with the client(s), clearly indicating which action items are the responsibility of the client and provider. **Goal types:** *Childcare, Emergency Services, English Language Training, Employability Assessment, Enrollment Into and Tracking of External Services, Health Needs, Home Management, Outreach Services, and Transportation*

Short-Term Case Management Goals

Examples of Short-Term Goals:

- ✓ Access to Reliable Transportation
- ✓ Secure Childcare Services
- ✓ Improve English Proficiency
- ✓ Acquire Transferable Job Skills
- ✓ Acquire Entry-Level Employment
- ✓ Provide U.S Systems and Conventional Customs Education
- ✓ Address/Health Needs *(provide copies of medical records if applicable)*
- ✓ Access to Immigration Services, e.g., assistance with acquiring employment authorization
- ✓ Access to Additional Life Skills Training
- ✓ Provide education and inquire about home safety

Goal One Title: _____

Goal One Description:

1. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

2. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

3. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

Goal Two Title: _____

Goal Two Description:

1. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

2. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

3. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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3.			
4.			

Progress Notes and Updates:

Long-Term Case Management Goals

Examples of Long-Term Goals:

- ✓ Access to Reliable Transportation
- ✓ Secure Childcare
- ✓ Improve English Proficiency
- ✓ Acquire Transferable Job Skills
- ✓ Acquire Entry-Level Employment
- ✓ Provide U.S Systems and Conventional Customs Education
- ✓ Address /Health Needs (*provide copies of medical records if applicable*)
- ✓ Access to Immigration Services, e.g., assistance with acquiring employment authorization
- ✓ Access to Additional Life Skills Training
- ✓ Provide education and inquire about home safety

Goal One Title: _____

Goal One Description:

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Progress Notes and Updates:

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Progress Notes and Updates:

Goal Two Title: _____

Goal Two Description:

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3. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

Plan for Other Services and Referrals:

Services	A. Referral Interest: Yes/No	B. Reason	C. Service Begin Date	D. Referral Comments	E. Client's Initials
Case Management					
Case Management - New Enrollee					
Outreach Services					
English Language Support					
Wellness Group Activities					
Healthcare Navigation and Support					
Health Education and Outreach					
Information and Referral					
Civic and Vocational Advancement					
Childcare Services					
Citizenship					
US Civics Instruction & English Language Civics Instruction					
Translation and Interpretation					
Parent Focused Assistance					
After-School Activities					
In-School Services					
Immigration Legal Assistance					

Employment (Current State)

Do you have Employment Authorization Documents (EAD)? Yes No

If yes, EAD Number: _____

If no, do you need assistance with employability paperwork? Yes No

Are you currently employed? Yes No

If yes, current employer? _____

Current position: _____ Current work schedule: _____

Current hourly wage: _____ Hours: Full-Time Part-Time

What were the dates of your most recent employment (MM/YYYY-MM/YYYY): _____

What was your job title? _____

What were your job duties? _____

Do you have any other work experience? Yes No

Employment History (Both US and International)

1. Employer: _____

Position: _____ Dates: _____

Address: _____

Duties: _____ Retention Rate: _____

Accomplishments, Certification, Skills Acquired: _____

2. Employer: _____

Position: _____ Dates: _____

Address: _____

Duties: _____ Retention Rate: _____

Accomplishments, Certification, Skills Acquired: _____

3. Employer: _____

Position: _____ Dates: _____

Address: _____

Duties: _____ Retention Rate: _____

Accomplishments, Certification, Skills Acquired: _____

4. Employer: _____

Position: _____ Dates: _____

Address: _____

Duties: _____ Retention Rate: _____

Accomplishments, Certification, Skills Acquired: _____

5. Employer: _____
Position: _____ Dates: _____
Address: _____
Duties: _____ Retention Rate: _____
Accomplishments, Certification, Skills Acquired: _____

6. Employer: _____
Position: _____ Dates: _____
Address: _____
Duties: _____ Retention Rate: _____
Accomplishments, Certification, Skills Acquired: _____

7. Employer: _____
Position: _____ Dates: _____
Address: _____
Duties: _____ Retention Rate: _____
Accomplishments, Certification, Skills Acquired: _____

8. Employer: _____
Position: _____ Dates: _____
Address: _____
Duties: _____ Retention Rate: _____
Accomplishments, Certification, Skills Acquired: _____

9. Employer: _____
Position: _____ Dates: _____
Address: _____
Duties: _____ Retention Rate: _____
Accomplishments, Certification, Skills Acquired: _____

10. Employer: _____
Position: _____ Dates: _____
Address: _____
Duties: _____ Retention Rate: _____
Accomplishments, Certification, Skills Acquired: _____

Employment Considerations

Do you have any religious convictions that may affect job entry? *(Check all that apply)*

- None No Fridays No Saturdays No Sundays
- Long Head Covering Short Head Covering No Pork Handling No Beef Handling
- Religious Holiday Observances Other _____

Do you have lifting restrictions? Yes No

If "Yes", what are the restrictions? _____

Are you able to stand for an entire 8-hour shift? Yes No

Do you have any health issues that would affect your ability to work? Yes No

Do you have any mental health issues that would affect your ability to work? Yes No

What shifts are you able to work? 1st Shift 2nd Shift 3rd Shift 4th Shift

If you stated earlier in the assessment that you have dependents, are you using child care? Yes No

If not, do you need assistance with acquiring child care? Yes No

Transportation plan, if applicable:

Training plan, if applicable:

Child Care plan, if applicable:

Employment Plan

Use this form to develop an Employability Plan with the client(s), clearly indicating which action items are the responsibility of the client and provider. **Goal types:** *Childcare, English Language Training, Employability Assessment, Enrollment Into and Tracking of External Services, Job Acquisition, On the Job Training, Outreach Services, Skills Recertification, Transportation, and Vocational Training.*

Short-Term Goals

Examples of Barriers to Employment:

- | | |
|--|--|
| <ul style="list-style-type: none"> ✓ Access to Reliable Transportation ✓ Secure Childcare Services ✓ Improve English Proficiency ✓ Acquire Transferable Job Skills ✓ Acquire Entry-Level Employment ✓ Provide Orientation to Workforce Customs and Norms | <ul style="list-style-type: none"> ✓ Address / Health Needs That Affect Employment
<i>(provide copies of medical records if applicable)</i> ✓ Assistance with Work Authorization ✓ Access to Immigration Services, e.g., assistance with acquiring employment authorization |
|--|--|
-

What types of work are you interested in doing?

Job objective / positions:

Goal One Title: _____

Goal One Description:

1. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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2.			
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Progress Notes and Updates:

2. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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Progress Notes and Updates:

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1.			
2.			
3.			
4.			

Progress Notes and Updates:

Goal Two Title: _____

Goal Two Description:

1. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

2. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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2.			
3.			
4.			

Progress Notes and Updates:

 3. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

Long-Term Goals

Examples of Barriers to Employment:

- ✓ Access to Reliable Transportation
- ✓ Secure Childcare Services
- ✓ Improve English Proficiency
- ✓ Acquire Transferable Job Skills
- ✓ Acquire Entry-Level Employment
- ✓ Provide Orientation to Workforce Customs and Norms
- ✓ Address / Health Needs That Affect Employment
(provide copies of medical records if applicable)
- ✓ Assistance with Work Authorization
- ✓ Access to Immigration Services, e.g., assistance with acquiring employment authorization

Goal One Title: _____

Goal One Description:

1. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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Progress Notes and Updates:

2. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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Progress Notes and Updates:

3. Barrier Description to Achieving Goal One:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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Progress Notes and Updates:

 Goal Two Title: _____

Goal Two Description:

1. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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Progress Notes and Updates:

 2. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
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Progress Notes and Updates:

3. Barrier Description to Achieving Goal Two:

Actions Taken to Overcome Barrier <i>(Each action should state who will do what, and when)</i>	Action Due Date	Updates on Action	Action Completed Date
1.			
2.			
3.			
4.			

Progress Notes and Updates:

Employability Related Services and Referrals					
Services	A. Referral Interest	B. Reason	C. Service Begin Date	D. Referral Comments	E. Client's Initial
Employability Assessment	Yes No				
Pre-Employment	Yes No				
Job Development	Yes No				
Employment Follow-Up	Yes No				
Employment Transportation	Yes No				
Initial Employment	Yes No				
Current Job Placement	Yes No				
ELT-Advanced	Yes No				
ELT-Intermediate	Yes No				
ELT-Beginner	Yes No				
English Language Training	Yes No				
ELT (Referral)	Yes No				

Attestation

I certify that I have explained all case management services provided under this program, and all information provided to me by the client has been recorded accurately. I worked with the client(s) to jointly develop self-sufficiency goals according to the form provided in this document. Furthermore, I have discussed with the client their rights under this program and provided contact information.

Agency Staff Name: _____

Agency Staff Signature: _____ **Date:** _____

I certify that all case management services provided under this program have been explained to me clearly. I understand that I am eligible to use any service provided under this contract, regardless of the services of interest I indicated on this form. The case management service provider has provided me with contact information or a way for me to reach out and contact the case management service provider should I have any questions or require additional assistance.

Client Name: _____

Client Signature: _____ **Date:** _____

Interpreter Name: _____

Interpreter Signature: _____ **Date:** _____

Progress Follow-Up: Week One

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Progress Follow-Up: Week Two

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Progress Follow-Up: Month One

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Progress Follow-Up: Month Two

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Progress Follow-Up: Month Three

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Progress Follow-Up: Month Six

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Progress Follow-Up: Year One

Meeting Date: _____ Meeting Time: _____

Method of Contact: Face-to-Face Phone Email Other: _____

If face-to-face meeting, location of the meeting. Please enter N/A if the method of contact is not face-to-face:

Key Areas of Discussion:

Progress:

Future Action:

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Aging and Adult Services at 602-542-4446; TTY/TDD Services 7-1-1 • Disponible en español en línea o en la oficina local