CITY AND COUNTY OF HONOLULU, SECTION 8 RENTAL ASSISTANCE BRANCH

Family Self-Sufficiency Program

INDIVIDUAL TRAINING AND SERVICE PLAN

PRINT NAME: (Last Name, First Name and M.I.) ______ **Social Security Number** ______ **Nickname** ______

Today's Date ______ **Annual Exam Date** ______ **Date of Last Exam** ______ **Section 8 Examiner/Phone No.** ______

FINAL GOAL: *To be gainfully employed based on my education, training, skills, and available job opportunities.*

INTERIM GOAL: *To be free of CASH/FINANCIAL Welfare assistance for at least -12- consecutive months prior to the end of my family's FSS Contract of Participation.*

Contact Information:

☐ Address listed w/Section 8 Lease ☐ Change, P.O. Box: ___________________ City/Zip Code: ____________________

Home Phone Number ______ Cellular Phone/Message/E-Mail Number ______ Name of Emergency Contact & Phone No. ______

I, the undersigned, certify that:

- The contents listed in this Individual Training and Service Plan (ITSP) was developed with my FSS Case Manager. He/She has helped me identify the obstacles and barriers that have prevented me from reaching my goals. I understand that my Case Manager cannot promise or guarantee resources at any time. However, he/she will make every effort to secure the resources needed to help me overcome the barriers/obstacles identified in this ITSP, so that I will achieve my FSS goals.
- I understand that this ITSP may be modified by mutual agreement with my FSS Case Manager;
- Based on the information contained in this ITSP, I will achieve all of the activities, steps, objectives and goals in the FSS Program. I understand that if I or any adult family member who is participating in the City's FSS program, especially the Section 8 Head of Household of my family, fails to achieve and fulfill all of the conditions, obligations, and goals outlined in our family's Contract of Participation, I/we *"forfeit the possibility of receiving any FSS monetary savings escrow that we may be deemed eligible for"* with the FSS Program of the City and County of Honolulu.
- I understand that I will be required to maintain contact with my FSS Case Manager monthly, quarterly, or more, if determined by my FSS Case Manager. Contacts may consist of: *In person, attendance at workshops, telephone, phone messages, email, information sent through the postage mail system, and other contact methods to ensure compliance of the FSS Program.*

______ Signature of FSS Participant ______ Date ______ Signature of FSS Case Manager

1. PERSONAL INFORMATION:

Current Age ______ Date of Birth (MO/DA/YR) ______ Place of Birth ______ Name of Country ______

USA Citizenship/Legal Alien Status: ☐USA/US Naturalization ☐ Resident Alien ☐ Other: ____

Alien Card No: **A#**:____ Expiration Date:__________________________________

Primary language used: ____ Proficient in: ☐ Reading ☐ Conversation ☐ Writing

English Proficiency: ☐ Primary Language Used ☐ 2nd Language Used Proficient in: ☐Reading ☐ Conversation ☐ Writing

Comments: ____

2. EDUCATION:

Participant's Name: ______________________

Circle highest grade completed: *Up to 8* 9 10 11 12 ☐ Has Diploma from: ☐ H/S ☐ CB ☐GED College: 13 14 15 16 17+

If dropped out of school, list reason: ______________________ **Grade Dropped:** ________

Name of last school attended: ______________________ City/State: ______________

☐ Interested in returning to school ☐ Has returned to school and is enrolled in a similar job training and/or educational program

Name of Vocational School/College: ______________________ City/State: ______________

Course: ______________________ Stat: (Mo/Yr) ________ End: (Mo/Yr) ________

Will receive: ☐ Diploma ☐ Certificate ☐ Certification ☐ Associate Degree ☐ 4 Yr./Bachelor's Degree ☐ 6 Yrs/Master's+

3. ARMED FORCES/MILITARY EXPERIENCE:

☐ N/A: No military experience ☐ Has military training and experience ☐ Is a U. S. Veteran ☐ Is a Veteran from another country

Branch: ______________________ Dates of Service: From: ____________ To: ____________

Rank:______________________ Discharge Information: ☐ Honorable ☐ Dishonorable ☐ Medical ☐ Other than Honorable

Medical/Special Needs Condition: ☐ N/A-None ☐ Condition exists, special needs already met; ☐ Requests assistance

______________________ ______________________

Name of Condition Type of accommodations needed to enhance self-sufficiency goal

4. WORK EXPERIENCE (Paid and/or Volunteer):

Type of Experience: ☐ None ☐ Paid ☐ Volunteer ☐ Other Self-Sufficiency Program ☐ WTW or FTW Experience

Current or most recent employer: ______________________ City/State: ____________ Phone No.: ____________

Name of Position: ______________________ Work Hours Per Week: ________ Wage Per Hour: ________

Duties: ____

Started (Mo/Yr): ________ End Date (Mo/Yr): ______________ Reason for Termination: ______________

EMPLOYMENT HISTORY

EMPLOYER'S NAME	JOB TITLE	Start & End Dates	Wkly Hrs	Hourly Pay	Termination Reason

(List additional experience as an attachment to this ITSP)

5. BARRIER IDENTIFICATION AND REMOVAL PLAN:

Participant's Name: ____________________

BARRIER/OBSTACLE IDENTIFIED	REMOVAL PLAN	RESPONSIBILITY FSS	Part.	Resource Agency	Est. Time Start/End Dates
Armed Forces/Military: ☐ Negative discharge, needs retrain. ☐ Health Condition, needs work/ special needs accommodations ☐ Health condition, needs medical referrals for help ☐ Other:	**N/A**				
Basic Needs/Gov. Resources: ☐ **Lacks resources for:** ☐ N/A ☐ Clothing ☐ Food ☐ Furniture ☐ Medical/ Sp. Needs ☐ SSA ☐ SSI ☐ SSDI	**N/A at this time**				
Career/Skills Assessment: ☐ Lacks Career Assessment ☐ Provided by other agency ☐ Needs testing to determine levels ☐ Other:	**FSS Program**	**X**	**X**	**9/8/2007** **9/07 – 10/008**	**3 Hrs.** **2-3 Hrs.**
Disabled/Special Needs: ☐ N/A ☐ Condition interrupted goal ☐ Is disabled, condition is:	**Address barriers w/part-time work to meet work Capabilities**	**X**	**X**	**FSS** **OWL** **DVR** **Othr referrals**	**10/08-10/2012**
Education: ☐ Lacks H/S Diploma/GED ☐ Wants to get H/S diploma or GED ☐ Lacks $$$ for school/sp. train/supplies ☐ Lacks education due to health condition/special needs condition ☐ Attending Diploma/GED Program ☐ Needs to improve academic levels ☐ Feels academically deficient in: ______Reading ______Math ☐ English is ESL, has deficiencies ☐ Needs: ☐Reading ☐Writing ☐Communication ☐ Lang. Experience ☐ Needs post-sec. education/training ☐ Wants to attend college/voc. training ☐ Other:	**Links w/DVR and other resources to help address educational and entrepreneurialship goals**	**X**	**X**	**FSS** **DVR** **PACT** **OWL** **Otr Resource Agencies** **ETC Programs For Culinary Arts, then employment**	**10/08 – 10/2012**
Employment: ☐ Lacks skill certification or experience ☐ Needs Pre-Employ/Job Search Skills ☐ Needs retraining: RIF/Bus. Closure ☐ Needs resume /referrals for jobs ☐ Lacks F/T work, needs job search/ placement assistance ☐ Lacks work maturity or retention skills ☐ Lives in area w/limited opportunities ☐ Needs equip/supplies/uniforms, etc. ☐ Other:	**Same as above**				**10/07 – 10/2012**

BARRIER/OBSTACLE REMOVED	REMOVAL PLAN	FSS	Part.	Resource Agency	Est. Time (Start/End Dates)
Family/Household Members: ☐ Spouse ☐ Partner ☐ Children ☐ Disabled/Elderly Adult **Name** **Age** ***Family Care Needs:*** ☐ N/A ☐ Child-Care ☐ Adult Day Care ☐ After-School ☐ Eve/Sat-Sun ☐ Other:	**N/A at this time**				
Financial/Credit Needs: ☐ Needs Budget Mgmt training ☐ Has poor credit history, needs credit counseling/rebuilding services ☐ Lacks credit stability - homeownership ☐ Other:	➢ **N/A for credit (785 pts)** ➢ **Refer for Budget Mgmt** ➢ **Time Mgmt** **Links to above as needed**			**As needed**	
Life Coping/Enhancement Skills: ☐ Anger/Stress Management ☐ Balancing Family/Work/School ☐ Budget Management Skills ☐ Credit Counseling/Management ☐ Lacks Time Management Skills ☐ Parenting Skills ☐ Self-Esteem/Confidence Building	**FSS to look for links to assist w/self-esteem building, mentoring**	**X**	**X**	**Links to resource providers**	**10/07 – 10/1010**
Personal: ☐ Abuse: ☐ No Abuse Exits = N/A ☐ Victim ☐ Offender ☐ TRO ☐ Domestic ☐ Gangs ☐ Substance ☐ Attitude (Negative/Comfort Zone) ☐ Behavior (Negative/Comfort Zone) ☐ Has Criminal History: ☐ Misdemeanor(s) ☐ Felonies ☐ Has Warrants ☐On Parole/Probation ☐ Emotional/Health/Mental Needs ☐ Lacks interpersonal skills ☐ Lacks Independent living/ ☐ Stress/Anger (Extreme Stress):	**See above**				
Transportation: ☐ Has a Valid Driver's License: Type: __Reg ___CDL ___Motorcycle DL #:_____________________________ State:___________________________ Exp. Date:________________________ ☐ Lacks transportation ☐ Lacks valid driver's license due: ☐ No auto i**nsurance coverage** ☐ Outstanding traffic violations ☐ Substance/DUI Abuse	**N/A at this time, will review through program duration**				

6. PARTICIPANT'S GOALS:

FINAL GOAL: *To be gainfully employed based on my skills, education, training and available job opportunities.*

INTERIM GOAL: *To be free from welfare (cash/financial) assistance for at least -12- consecutive months before the end date of my FSS Contract of Participation.*

ACTIVITIES/SERVICES/INTERIM GOALS	RESPONSIBILITY FSS	PART.	RESOURCE AGENCY	Est. Time (Start/End Dates)	Date Completed:
***Please refer to HUD form 52650** **(HUD's 52650 ITSP forms (2 or 3 additional pages) included in this ITSP packet.)** **Name of FSS Participant**					

I, the undersigned, re-certify on the last page of this ITSP that:

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PRINT Participant's Name ____________ Signature of FSS Participant ____________ Date ____________ FSS Case Manager's Signature ____________