KANSAS REHABILITATION SERVICES ACTION PLAN

Consumer Name: _____ **Contractor Name:** _____

_____ _____

Consumer Signature **Contractor Signature**

Service Authorization #: _____ **Service Authorization Date:** _____

Date of Action Plan: _____

Reporting Frequency: _____ **RS Counselor Name:** _____

Type/Level of Service:

_____ _____

RS Counselor Signature

Identified consumer conditions and preferences:

Identified barriers:

Action Steps to achieve service goal (see instructions):

Action Steps to achieve service goal (continued):

KANSAS REHABILITATION SERVICES ACTION PLAN REPORT

Consumer Name: _____

Service Authorization No: _____

Type/Level of Service:

_____

RS Counselor Name: _____

Date of Report: _____

Dates covered by this report:

_____

Contractor Name: _____

_____
Contractor Signature

Contracted Service Status

☐ **Progress meets payment criteria**

☐ **Progress Demonstrated**

☐ **Successfully Completed Service**

☐ **Service Interrupted: (date)** _____
Why?

_____

When will services resume? _____

☐ **rvice Ended:** _____
Why?

_____

15 day notice needed? Yes ☐ **No** ☐

Job Obtained/Employment Information

Employer: _____ **Job Title:** _____

Supervisor: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Start Date: _____ **Hourly Wage: $** _____ **Hours per Week:** _____

Employment Benefits: Health Benefits ☐ **Vacation Leave:** ☐ **Sick Leave:** ☐

Employment End Date: _____

Report On Progress Of Action Steps (see instructions)

KANSAS REHABILITATION SERVICES ACTION PLAN REPORT

Report On Progress Of Action Steps (continued)