PLAN FOR SUPPORTING MYSELF AND FAMILY

Line No.	NAME:		Social Security No.
01	Diana Cowelly		XXXX
County	CASE NO:	TELEPHONE NO:	DATE:
22	xxxxxxxxx	555-5432	5/28/04

AGREEMENT OF MUTUAL RESPONSIBILITY

GOALS:

My long term goals:

To become a welfare caseworker.

My goal for the next six months:

To comply with the requirements of the Maximizing Participation Project (MPP).

Number of TANF Days __*1830*__ GA Days __*0*___ used to date
Time Out Begins ___/___/___ Time Out Ends ___/___/___
Initial Job Search Completed **Y** / ~~NO~~
Highest Education Level Completed ___*12th Grade*___
Birth Date of the Youngest Child_____
Paid Work Experience Weeks Completed ____*0*___
Allowable Community Service Hours Per Week _N/A_

Employment & Training Status:

☒ Exempt ☐ Mandatory With Good Cause ☐ Mandatory

BARRIERS TO BEING ABLE TO SUPPORT MYSELF AND FAMILY:

- *Has a chronic medical condition per completed medical assessment form (PA 1663).*
- *Sporadic work history.*
- *Not receiving child support as father is currently unemployed.*
- *Could not complete cosmetology school.*

PLAN TO ADDRESS BARRIERS/FAMILY ISSUES:

- *Follow treatment plan presented by your doctor.*
- *Continue to pursue child support.*
- *Cooperate in the completion of your MPP Service Plan and your Work Capacity Assessment.*
- *Follow treatment plan prescribed by your doctor.*
- *Ensure child attends school and progresses.*
- *Cooperate with DAP process including working with your DAP worker and appealing a denial of disability benefit if the denial is based on medical reasons.*
- *Attend all scheduled MPP appointments.*

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01	*Diana Cowelly*		XXXX
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AGREEMENT OF MUTUAL RESPONSIBILITY

PARTICIPATION ACTIVITIES:

Good Cause has been reviewed and is:

☐ Granted ☐ Denied ☒ Not Applicable

Number of hours required to participate_____

What: Maximizing Participation Project

Where: *Local CAO*
222 Main St.
Anytown, PA

When:
Friday, 6/4/04 at 10:00 am

Hours: To be determined

Number of hours required to participate_____

What:

Where:

When:

Hours:

AGENCY HELP:

- *Issue transportation allowance (bus fare) as needed.*
- *Review benefits of MPP participation.*
- *Continue to monitor Ms. C.'s progress every 6 months (or more often as needed).*
- *Assist Ms. C. in completion of any necessary medical forms.*
- *Explain reporting requirements.*
- *Referred to DAP.*

Report on this plan to I.M. Caseworker **by:** *__06_/_4__/_2004_ (_717_)_555_-__XXXX_*

I have read and understand this agreement. I understand that signing this agreement is a condition of eligibility and that the penalties, listed on page 5 of this form, may be imposed if I willfully fail, without a good cause (good reason), to complete mandatory activities. I agree to take the actions outlined in this plan. (62 P.S. 405.3)

The agency will provide services to help you, to the extent possible, so you can complete the actions outlined in your plan.

Diana Cowelly		*5/28/04*
Customer Signature		Date
I.M. Caseworker		*5/28/04*
Agency Signature		Date