



INITIAL FAMILY DEVELOPMENT PLAN

Please print clearly and sign on page two. Thank you!

Name: _____ Date of Birth (mm/dd/yyyy): _____ Last 4 of SSN: _____

Town where you live: _____ Phone number: () _____ Email address: _____

Best way to reach you: Phone Text Email

Please share any of the following information you would like us to know to help you reach your goals

1. What goal(s) would you like to work on while participating in the Reach Up program?

2. Do you have transportation to get to your first appointment with your Reach Up case manager? Yes No

3. Are you currently experiencing homelessness? Yes No

If NO, do you have a rental obligation? Yes No

4. Please check the box next to the other services or organizations your family is connected to that you would like us to know about. We may be able to partner with them to help you meet your goal(s).

<input type="checkbox"/> SUBSTANCE USE TREATMENT SERVICES	<input type="checkbox"/> CHILD CARE SUBSIDY	<input type="checkbox"/> CHILDREN'S INTEGRATED SERVICES (CIS)
<input type="checkbox"/> DCF - FAMILY SERVICES DIVISION	<input type="checkbox"/> DEPARTMENT OF LABOR (DOL)	<input type="checkbox"/> DOMESTIC VIOLENCE AGENCY
<input type="checkbox"/> HEAD START/EARLY HEAD START	<input type="checkbox"/> MENTAL HEALTH COUNSELING	<input type="checkbox"/> PARENT CHILD CENTER
<input type="checkbox"/> PUBLIC HOUSING	<input type="checkbox"/> PROBATION & PAROLE	<input type="checkbox"/> VOCATIONAL REHABILITATION (VocRehab or VR)
<input type="checkbox"/> FAMILY SUPPORTIVE HOUSING	<input type="checkbox"/> COMMUNITY ACTION AGENCY HOUSING NAVIGATOR/CASE MANAGER	<input type="checkbox"/> FAMILY SELF-SUFFICIENCY PROGRAM

Other: _____

5. Is there anything else that you would like your case manager to know about?

REACH UP TO REACH AHEAD

When you leave Reach Up, you may qualify for Reach Ahead — a program that helps people move from Reach Up to work. You'll automatically be enrolled if you're eligible. Benefits could include cash incentives for working, help paying for things like car repairs and work clothes, the highest child care subsidy available, money for food and help finding things like housing and child care.

Initial this box if you DON'T want to be automatically enrolled

STATEMENTS OF AGREEMENT

If I'm found eligible for Reach Up or Reach First, I agree to:

- ✓ Attend scheduled appointments & assessment activities.
- ✓ Set employment or other related goals.
- ✓ Participate in all program activities listed on my Family Development Plan.
- ✓ Sign this form. *It is a required part of applying (Reach Up rule 2330). If I don't sign, my application will be denied for failing to meet a condition of eligibility (Reach Up rule 2216.1B).*
- ✓ Tell my case manager right away if something comes up that makes it difficult for me to participate.
- ✓ Meet my requirement for participating in Reach Up/Reach First:
 - o Reach Up: my case manager will tell me how many hours a week I must work or participate in other activities (called my *work requirement*).
 - o Reach First: I will become self-sufficient within 4 months.

SIGNATURE

By signing this form, I confirm that I agree to the statements listed above and I understand the information I was provided about Reach Up/Reach First as well as my rights and responsibilities that are outlined on the next page.

Signature of Participant

Date

Signature of Participant #2 (if applicable)

Date

ESD: Original to RU assignment team. One copy to participant, one copy to OnBase.

Your Responsibilities: you must fully comply with all activities in your Family Development Plan (FDP) and inform your Reach Up case manager right away of any changes in your situation that may cause your FDP to change or make you unable to meet your work requirement. (Rule 2330, 2334).

Your Rights: if you have a complaint related to your participation in this program, you can ask for a fair hearing before the Vermont Human Services board. This is called filing an appeal. To request a fair hearing or learn more about the decision, call the Benefits Service Center at 1-800-479-6151. If you request a fair hearing before the department stops or changes your benefits, you may have your benefits continue unchanged while your appeal is pending. If you want your benefits to continue unchanged during your appeal, you must request this before the date your benefits are due to close. If you ask the department to continue your benefits and you lose the appeal, the department may ask you to pay back any benefits you should not have received. If you ask the department to reduce or stop your benefits and you win the appeal, the department will repay any benefits that were reduced or stopped. You must ask for a fair hearing within 90 days of the date the department mailed you this notice. If the department denied your application or stopped your benefits, you may reapply at any time, including while your appeal is pending. If you reapply, your benefits will not be approved unless you are eligible. You may ask someone you trust to help you ask for a fair hearing. Call Vermont Legal Aid at 1-800-889-2047 to find out if you qualify for free legal help.

Rights of People with Disabilities: the *Americans with Disabilities Act (ADA)* and Vermont law say we must make *reasonable accommodations* to help people with disabilities get public benefits. If you have a physical, mental or learning condition that makes it hard to do the things we ask you to do, we may be able to make some changes to help. Here are some examples of changes we can make:

- Someone can write down your answers if you can't
- We can give you more time or help you get the documents you need to give us
- You can have a support person with you when you talk to us
- We can send documents with a larger print, so you can read them
- We can meet in your home or by phone, so you don't have to come to the district office If you need us to make changes so you can get benefits, let us know.

ATTENTION: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 1-855-247-3092. (Arabic)

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-247-3092. (French) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-247-3092. (Spanish)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-247-3092. (Vietnamese)

यान दिवहोस् तपाइले े नेपाली बो नहु ु छ भने तपाइको िनि त भाषा सहायता सेवह िनःश क पमा उपल ध छ । फोन गनःहोस् 1-855-247-3092। (Nepali)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-247-3092. (German)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-247-3092. (Cushite)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-247-3092. (Russian)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-247-3092. (Portuguese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-247-3092 まで、お電話にてご連絡ください。 (Japanese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-247-3092。 (Chinese)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-247-3092. (Italian)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. –Nazovite 1-855-247-3092. (Serbo-Croatian/Bosnian)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-247-3092. (Tagalog)

เรียน: ถาคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-247-3092. (Thai)