Self-Sufficiency Agreement

Name: _____ **Date:** _____

ID Number: _____ **TANF Months Remaining:** _____

My Motivation (Why I Work)**:** _____

Professional Goal: _____

My Plan: Completed by:

1. _____
2. _____
3. _____

How DCF will support My Plan: Completed by:

1. _____
2. _____

I have been part of the decision making and understand that the above agreement requires my participation and cooperation.

I have received a copy of this agreement and understand my rights and responsibilities as well as those of DCF.

I will notify my worker if any changes occur in my present situation that may require an adjustment to this plan and/or a change in employment status.

I understand that if I choose not to follow through with this plan that I have made the choice to receive a penalty which will close my cash benefits and reduce my food assistance.

Client Signature: _____

Client Phone Number: _____

Client Email: _____

Career Navigator Signature: _____

Career Navigator Phone Number: _____

Career Navigator Email: _____

Next Appointment Date

Date: _____

Time: _____

Would you like to receive a reminder by:

Email Phone Call Text

Steps to Achieve My Plan:

☐ I will register with KansasWorks by

☐ I will work with my Career Navigator to

by

☐ I will attend all appointments scheduled for me with my Career Navigator and providers that referrals have been made for me for the length of my plan.

☐ I will pursue medical coverage and keep the coverage once it has been approved for the duration of my plan.

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