Rev 10/15

Self-Sufficiency Agreement

Name: ____________________________________ **Date:** ______________________

ID Number: ____________________________________

Short-term Goal: ____

Long-term Goal: ____

What I need to do: Completed by:

1. ____

2. ____

What DCF will do: Completed by:

1. ____

2. ____

Comments:

I will attend all appointments scheduled for work programs. This includes appointments with the case manager, medical providers, and providers that referrals have been made to for my self-sufficiency agreement.

I understand that I am required to pursue medical coverage (DCF/KDHE) and that I am required to keep that coverage once it has been approved. If I fail to follow thru with applying, getting and/or keeping medical coverage, I will be considered in non-cooperation with my work requirement and I will be penalized.

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: ______________________________

Career Navigator Signature: ______________________________

Career Navigator Phone Number: ______________________________

Next Appointment Date

Date: ________________

Time: ________________