OVR 5C

(rev. 01/2024)

Kentucky Office of Vocational Rehabilitation Trial Work Experience Plan Continuation Form

Kentucky Career Center
Vocational Rehabilitation

1. CONSUMER INFORMATION

Name	Case Number

2. VOCATIONAL SERVICES

The following vocational services paid for by the Office of Vocational Rehabilitation (OVR) are needed:

Service 1

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 2

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 3

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 4

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 5

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	

Funding Source(s)

Service 6

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

Service 7

Service	Begin Date *(MM/DD/YYYY)*
Detailed description or service specifics	
Vendor or Service Provider Name	
Funding Source(s)	

4. COMMENTS

Provide Additional Comments or Details

5. PERMISSION AND SIGNATURES

- I give permission for Vocational Rehabilitation and the school/facility of my choice and/or SSA to share financial and other information to carry out my Individualized Plan for Employment (IPE).
- I understand that the Office of Vocational Rehabilitation (OVR) services depend on the availability of State and Federal funds and/or openings at facilities/schools.
- If I have questions or concerns that cannot be addressed by my Rehabilitation Counselor, I will consult the Consumer Guide to find information on my rights, responsibilities, and the Client Assistance Program.
- I was given a copy of my Individualized Plan for Employment (IPE) by mail or electronically and am aware that my work plan will be reviewed annually.

Consumer's Signature _____ Date (MM/DD/YYYY) _____

Parent / Guardian Signature _____ Date (MM/DD/YYYY) _____

Vocational Rehabilitation Counselor's Signature _____ Date (MM/DD/YYYY) _____

Branch Manager's Signature (if applicable) _____ Date (MM/DD/YYYY) _____

Director of Field Services Signature (if appliable) _____ Date (MM/DD/YYYY) _____

Assistive Technology Branch Manager Signature (if applicable) _____ Date (MM/DD/YYYY) _____

Note: The Trial Work Experience Continuation form may be attached to the Trial Work Experience form when required services exceed the space available on these forms. The Trial Work Experience Continuation form must be completed at the same time as the Trial Work Experience form. Both forms must be signed, and dated and the dates must match.