

**IOWA DEPARTMENT FOR THE BLIND  
INDIVIDUAL PLAN FOR EMPLOYMENT  
CLIENT RESPONSE**

**Date:**

**To: Iowa Department for the Blind, 524 4th Street, Des Moines, Iowa 50309**

**I understand that the services identified in my Individual Plan for Employment and amendments will not go into effect without my signed agreement.**

**(The following space is provided for you to describe your participation in the development of your Individual Plan for Employment. For example, how did you decide on your job goal and related services? How did you choose which service providers to use? Please write your comments on this sheet or on a separate sheet. You may write them in print or Braille, as you prefer. Please sign the print copy of this form in the space provided, attach any additional comments, and return it to your counselor.)**

**It is my understanding that I may request changes in the plan as circumstances change.**

**Rehab Client \_\_\_\_\_**