Alaska Department of Health and Social Services
Division of Public Assistance

WORK SERVICES PROGRAM

FAMILY SELF-SUFFICIENCY PLAN ADDENDUM

Name: _____ Date of plan: _____

Client ID Number: _____

Intermediate Goals	Steps	Start Date	Review Date

Support Services needed to complete the plan (transportation, childcare, etc.):

Service:	Who will arrange for it?	Who will provide it?	Who will pay for it?

Participant Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

TA 2B (06-3870) rev 05/12