

Date: _____		Annual Service Plan			Original (<input type="checkbox"/>) Revision (<input type="checkbox"/>)		Time Period Covered by Plan	
County: _____				From:	To:			
Description of Contracted or State-provided Services	Contracted Amount by Funding Source	Total Number	Program Participants			Type of Agency* and Percent of Funds		
			0 - 12 Months	13 - 60 Months	Over 60 Months			
Employment	SS TAP Other							
ELT	SS TAP Other							
OJT/Skills Training	SS TAP Other							
Case Management	SS TAP Other							
Other (Employment)	SS TAP Other							
Subtotal								
Non-Employment	SS TAP Other							
County Admin (15% Admin Max)	SS TAP Other							
Grand Total	SS TAP Other							

*Type of Agency: A. State/ County, B. Mutual Assistance Association, C. Voluntary Agency, D. Community College, E. Adult Basic Education, F. Other Non-Profit Organization, G. _____ The total percentage for each individual service (i.e., Employment, ELT, etc.) under Type of Agency and Percent of Funds must equal 100%.