Annual Service Plan

Original ( ) Revision (☐)

Date: _____ **Time Period Covered by Plan** **From:** _____ **To:** _____

State or County: _____

Description of Contracted or State-provided Services		Contracted Amount by Funding Source	Total Number	Program 0 - 12 Months	Participants 13 - 60 Months	Type of Agency and Percent of Funds
	SS					
	TAP					
	Other					
ELT	SS					
	TAP					
	Other					
OJT	SS					
	TAP					
	Other					
Skills Training	SS					
	TAP					
	Other					
Case Management	SS					
	TAP					
	Other					
Other	SS					
	TAP					
	Other					

Type of Agency		
	A. State/ County	E. Adult Basic Education
	B. Mutual Assistance Association	F. Other Non-Profit Organization
	C. Voluntary Agency	G. _____
	D. Community College	