

The Self-Employment Assistance Program (SEAP) Individual Services Plan

Instructions: Use this form to list the 20 hours of training and skills development classes you will take to prepare for starting your business. If you need more space, attach additional sheets. **You do not have to complete the training or counseling before you send us this form.** However, the training must be completed during your time in the SEAP and by the due dates for the appropriate benchmark forms.

Submit this form online in your correspondence folder at www.labor.ny.gov/signin or scan this completed form and upload it through your online account, by fax to (518) 402-6586 or mail to the above address. If this form is not received by the due date, you will not be eligible for SEAP benefits from the date the form was due until the date the form was received.

Name: _____ Last four digits of Social Security Number: ____ _

Part I – Business Counselor Information

List contact information below for the business counselor you will be seeing while participating in the program and your first appointment date.

Business Counselor Name and Title: _____

Agency/Organization: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: (____) ____ - ____ 1st Appointment Date: ____ / ____ / ____

Part II – Training/Workshops Information

List **all 20 hours** of training classes that you plan on taking. If you must add or delete a class after you submit this form, call the SEAP Unit at (518) 485-1597.

School/Agency: _____ Phone Number: (____) ____ - ____

School/Agency Address: _____

City: _____ State: _____ Zip code: _____

Workshop/Class: _____

Training Dates: _____ Number of Hours: _____

School/Agency: _____ Phone Number: (____) ____ - ____

School/Agency Address: _____

City: _____ State: _____ Zip code: _____

Workshop/Class: _____

Training Dates: _____ Number of Hours: _____

School/Agency: _____ Phone Number: (____) ____ - ____

School/Agency Address: _____

City: _____ State: _____ Zip code: _____

Workshop/Class: _____

Training Dates: _____ Number of Hours: _____

School/Agency: _____ Phone Number: (____) ____ - ____

School/Agency Address: _____

City: _____ State: _____ Zip code: _____

Workshop/Class: _____

Training Dates: _____ Number of Hours: _____

School/Agency: _____ Phone Number: (____) ____ - ____

School/Agency Address: _____

City: _____ State: _____ Zip code: _____

Workshop/Class: _____

Training Dates: _____ Number of Hours: _____

School/Agency: _____ Phone Number: (____) ____ - ____

School/Agency Address: _____

City: _____ State: _____ Zip code: _____

Workshop/Class: _____

Training Dates: _____ Number of Hours: _____

Total number of hours = _____

I certify that the statements above are true and correct.

Signature: _____ Date: ____ / ____ / ____