

**PLACEMENT PLUS
TRIAD MEETING OUTCOME REPORT (P3-3a)**

Service Provider:

Consumer:	SSN #: XXX-XX-	Date:
Date of Triad Meeting:	DOR/QRP:	DOR/QRP Email/Phone #:

Triad Meeting Report

Identify specific reasons as to why the consumer is not ready to move onto the Job Readiness Skills Training phase of the service and provide applicable recommendations for consumer success.

Please list the specific reasons why this Department of Rehabilitation consumer is not ready for Job Readiness Skills Training:

Please provide applicable recommendations that you believe would prepare the consumer for Job Readiness Skills Training:

Additional Comments:

Request Meeting with DOR/QRP and Consumer

Service Provider Signature: 	Title:	Phone #:	Date Signed:
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Distribution: Consumer DOR/QRP Service Provider

NOTICE: This information is confidential. State law and regulations prohibit any further disclosure of this information without the informed, written consent of the person to whom this information pertains.