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| --- | --- | --- | --- |
| Candidate Name: | | | Candidate Cell: |
| Candidate Address: | | | Application Date: |
| Candidate email: | | | DOB: |
| Current School Program if applicable: | |  | |
| Mother/Guardian: | | Home Phone: | |
| email Address: | | Cell Phone: | |
| Father/Guardian: | | Home Phone: | |
| email Address: | | Cell Phone: | |
| ACCES-VR Status: | Do you have an open ACCES-VR case?  🞎 Yes 🞎 No | If yes: | Counselor Name: |
| Email Address: |
| Phone Number: |
| OPWDD Status: | Have you been approved for OPWDD services?  🞎 Yes 🞎 No | If yes: | Service Coordinator: |
| Agency/Phone Number: |
|  | Are you HCBS Waiver enrolled  🞎 Yes 🞎 No |  |  |
| Medicaid Status: | Do you receive Medicaid?  🞎 Yes 🞎 No | If yes: | Contact: |
| SSI Status: | Are you receiving SSI Benefits?  🞎 Yes 🞎 No | If yes: | Contact: |
| SSDI Status: | Are you receiving SSDI Benefits?  🞎 Yes 🞎 No | If yes: | Contact: |
| Guardianship: | Do you have guardianship? 🞎 Yes 🞎 No 🞎 Applied | | |

**SERVICE AGENCIES**

Are you working with any other agencies other than ACCES-VR and OPWDD (i.e. outside counselor)? 🞎 Yes 🞎 No

|  |  |
| --- | --- |
| **Agency Name** | **Purpose** |
|  |  |
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**EDUCATION BACKGROUND**

Diploma/Credential Achieved\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What related services (i.e: speech, counseling, OT) did you receive in school? Include how many times per week? (ex.: speech 3x)

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Were you ever suspended/excluded/removed from high school? 🞎 Yes 🞎 No

If yes, please describe:

Have you ever utilized services of a 1:1 aide? 🞎 Yes 🞎 No

If yes, what was the purpose?

Do you have or ever had FBA/BIP? 🞎 Yes 🞎 No

If yes, please attach.

How do you respond when upset, angry, or stressed? (i.e., deep breathing, walk away, yell, throw things, withdraw, physically aggressive, other)?

What strategies help calm you?

**VOCATIONAL/CAREER TECHNICAL EDUCATION COURSES (i.e.: Multi-Occ/Focus)**

Have you taken any vocational/career technical education courses? 🞎 Yes 🞎 No

If yes, which course was taken, and did you complete the course?

**EMPLOYMENT NEEDS AND GOALS**

Do you plan to pursue entry-level employment in the community upon exiting? 🞎 Yes 🞎 No

If yes, what kind of work do you want to do?

Upon exiting, do you want to work full-time or part-time? 🞎 Full-time (40 hour per week)

🞎 Part-time (20 hours per week)

Have you ever quit a job? 🞎 Yes 🞎 No

If yes, why?

List any specific disability accommodations:

**EMPLOYMENT BACKGROUND**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Unpaid Experiences*** |  |  |  |  |
| Employer |  |  |  |  |
| Dates of Service |  |  |  |  |
| Job Title |  |  |  |  |
| Job Duties |  |  |  |  |
| Supervisor’s Name |  |  |  |  |
| Contact Number |  |  |  |  |
| Job Coach | 🞎 Yes 🞎 No | 🞎 Yes 🞎 No | 🞎 Yes 🞎 No | 🞎 Yes 🞎 No |
| Reason for Leaving | 🞎 Voluntary Change  🞎 Fired  🞎 Other | 🞎 Voluntary Change  🞎 Fired  🞎 Other | 🞎 Voluntary Change  🞎 Fired  🞎 Other | 🞎 Voluntary Change  🞎 Fired  🞎 Other |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Paid Experiences*** | ***#1*** | ***#2*** |  |
| Employer |  |  |  |
| Dates of Service |  |  |  |
| Job Title |  |  |  |
| Job Duties |  |  |  |
| Supervisor’s Name |  |  |  |
| Contact Number |  |  |  |
| Job Coach | 🞎 Yes 🞎 No | 🞎 Yes 🞎 No |  |
| Reason for Leaving | 🞎 Voluntary Change  🞎 Fired  🞎 Other | 🞎 Voluntary Change  🞎 Fired  🞎 Other |  |
|  |  |  |  |

**EMPLOYABILITY SKILLS**

*Please check level that applies*

|  |  |  |  |
| --- | --- | --- | --- |
| ***To be completed by Applicant*** | Never | Sometimes | Frequently |
| I get easily distracted. |  |  |  |
| I get tired quickly. |  |  |  |
| I accept supervision. |  |  |  |
| I ask for help when needed. |  |  |  |
| I am honest. |  |  |  |
| I work quickly. |  |  |  |
| I have a positive attitude. |  |  |  |
| I follow dress codes. |  |  |  |
| I have good hygiene. |  |  |  |
| I handle constructive criticism appropriately. |  |  |  |
| I work well with others. |  |  |  |
| Checklists help me at work. 🞎 With pictures  🞎 Written |  |  |  |

Please list any health/medical restrictions that impact employment:

Have you ever had a Community Based Work Assessment? 🞎 Yes 🞎 No

If yes, attach copy.

**TRANSPORTATION**

I have: 🞎 Non driver’s license ID How do you get places now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Driver’s permit

🞎 Driver’s license

I take public transportation (RTS) alone. 🞎 Yes 🞎 No

I take public transportation (RTS) with support. 🞎 Yes 🞎 No

I am approved for RTS Access. 🞎 Yes 🞎 No

Do you have experience taking Lyft/Uber? 🞎 Yes 🞎 No

Alone? 🞎 Yes 🞎 No

With support? 🞎 Yes 🞎 No

Will you need assistance to plan your transportation to/from SELF?

🞎 Yes 🞎 No

I live on/near public transportation? 🞎 Yes 🞎 No 🞎 I don’t know

**SOCIAL SKILLS**

What social media do you regularly use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List 3 things that you like to do in your free time:

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_With friends 🞎 Alone 🞎 With Family

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_With friends 🞎 Alone 🞎 With Family

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_With friends 🞎 Alone 🞎 With Family

**MEDICAL**

*Medications / dosage / time of day taken by applicant*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dosage | Time of Day | Purpose | Self Administered? |
|  |  |  |  | 🞎 Yes 🞎 No |
|  |  |  |  | 🞎 Yes 🞎 No |
|  |  |  |  | 🞎 Yes 🞎 No |
|  |  |  |  | 🞎 Yes 🞎 No |

Do you wear glasses? 🞎 Yes 🞎 No Contacts? 🞎 Yes 🞎 No

If you are hearing impaired, please list aids/supports used:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is English your primary language? 🞎 Yes 🞎 No

Do you use sign language or other non-traditional forms of communication? 🞎 Yes 🞎 No

Does your family use sign language or other non-traditional forms of communication?

🞎 Yes 🞎 No

Please list aids/supports or assistive technology used:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DISABILITY AWARENESS (This should be completed by applicant or scribed using their own words.)**

Dear Applicant,

Please use this space to describe your disability and the effect it has on your daily activities at school/current program (if applicable), home, and in the community. (You may use an additional sheet if needed).

**OUTCOME AND GOALS**

Employment Desired Outcome:

Independent Living Desired Outcome:

Please list goal(s) you have in each area below that relate to your desired outcomes.

Employability Goal(s):

Independent Living Goal(s):

Social/Emotional Goal(s):

Please list the names and relationship to the candidate of those who assisted in completing this application.

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| --- | --- | --- | --- |
| **Name** | **Position/Relationship** | **Email** | **Phone Number** |
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I agree to the release of all pertinent school and medical records to the Arc of Monroe.

Information will be kept confidential and used only for program selection and agency referrals where applicable.

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| --- | --- |
| **Applicant Signature** | **Date** |
| **Parent Signature** | **Date** |
| **Signature of Legal Guardian** | **Date** |

**I UNDERSTAND THAT IF I AM ACCEPTED INTO THE PROGRAM**, I am agreeing to make a commitment to participate in the program, and that one or more of the following may be required per training site policies, procedures, and regulations: a TB test, flu shot, complete background check (***including fingerprinting***), etc.

|  |  |
| --- | --- |
| **Applicant Signature** | **Date** |
| **Parent Signature** | **Date** |
| **Signature of Legal Guardian** | **Date** |