Employment Program Intake
2018

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GROUP AND INDIVIUDAL SUPPORTED EMPLOYMENT PROGRAM ADMISSION AND RETENTION CRITERIA

The following is a listing of General Program Admission and Retention Criteria for individuals seeking or currently participating ServiceSource's Group and Individual Supported Employment services. Individuals requesting, referred, or participating in services must comply with these criteria:

1. The individual requests placement in the program.
2. The individual must be eighteen (18) years of age or older. Individuals between the ages of sixteen (16) and eighteen (18) years of age could be admitted, after favorable review by ServiceSource, provided that no child labor laws are violated.
3. The Individual must have a documented disability.
4. As determined by the referral and internal screening process, participation in the program is desired, beneficial, and appropriate for the individual.
5. The required referral documentation is current and available for review. This information may vary according to program and third-party funding/sponsor requirements and requirements are presented in the ServiceSource Intake Packet or from the Program Admission Team.
6. The individual should be in stable medical condition for the program environment. The Corporation may attempt to verify that the individual is free of communicable disease and is not in a crisis state.
7. The individual should not be considered to be a clear and continuing danger to self or others, or disruptive to the program or work environment.
8. The individual requesting services and family member(s) or a designated representative, as appropriate, must participate as members of the Interdisciplinary Team (IDT) and cooperate in the development and implementation of the program plan; e.g. meetings with ServiceSource personnel, obtaining medical reports, etc.
9. The individual must be willing and able to abide by all policies, regulations and safety practices of the program environment.
10. The individual must be able to follow oral, written, and/or demonstrated instructions within supervisory or support ratio.
11. The individual must be able to care for personal needs or have personal care assistance provided.
12. The individual must have transportation to and from the work or program site.
13. The individual must be able to self-administer medication.
14. The individual must have the funding necessary for the specific services.

PROGRAM PLACEMENT

Individuals will be considered for openings in the desired program within the constraints of the program capacity and the support requirements of the individual. ServiceSource is an equal opportunity employer. f no appropriate opening in the desired program exists at time of application, the individual will still be screened for services and put on a service request list. Generally, requests for program participation will be handled on a first come, first served basis, although, an individual or referral source may make a request for special consideration. Individuals will be notified of their service request list status at least semi-annually and requested to notify ServiceSource of their continued interest in participation.

PROGRAM EXIT CRITERIA

Individuals may be terminated from ServiceSource programs based on the following criteria:

General Exit Criteria:

1. The individual fails to meet and/or maintain the general admission/retention criteria or those for the specific service.

2. The individual and/or the Interdisciplinary Team request alternative placement.

3. Funding and/or job opportunity is no longer available.

Additional Exit Criteria for Community-Based Group Supported Employment:

1. The individual is terminated by the employer and/or host company.

Additional Exit Criteria for Individual Supported Employment:

1. The individual is terminated by employer.
2. The individual no longer needs support services as determined by consensus of the IDT and past successful record of employment.

PROGRAM RE-ADMITTANCE CRITERIA

In addition to the General Admission and Retention Criteria, the following issues are relevant to individuals seeking readmission into ServiceSource programs.

1. Individuals terminated from services for cause may be considered for readmission after ninety (90) days. Individuals applying for readmission must request so in writing and must meet admission and retention criteria. Consideration for readmission will include the specific cause of discharge/termination and the actions the individual has undertaken to ameliorate the factors contributing to the cause.

2. Individuals discharged for medical reasons must submit documentation from the attending physician of readiness to continue employment requirements or program activities.

3. Individuals who lose community-based jobs through no fault of their own within 90 days of placement may enter the center based program if desired by the individual and approved by the funding source. Beyond 90 days of placement or, in the instance of termination for cause, regular admission practices apply.

HUMAN RIGHTS INFORMATION

ServiceSource strives to provide individuals with the best possible services. All program participants have rights that are protected by government regulations. The following is a summary of your rights when participating in a ServiceSource program.

- To be treated with dignity and respect.
- To receive services regardless of race, religion, sex, disability, national origin, age, or ability to pay.
- To receive help in the development of your treatment or program plan.
- To privacy.
- To confidential handling of records.
- To be protected from harm and abuse.
- To receive services in a safe and clean place.
- To ask questions and get help with your rights.
- To have your complaints resolved.

APPLICANT DOCUMENT CHECKLIST

You may use this page as a "checklist" when applying for services

The following forms or documents are needed for all ServiceSource Program Offerings			
√	**Form or Document**	**Explanation**	**Found on Page:**
	1. ServiceSource Referral form	States the service(s) that are being requested. A referral letter may be substituted or included as an addition to the ServiceSource referral form. This form does not need to be completed for self-referrals.	7
	2. Documentation of Disability	A written report **signed** by a licensed physician, psychiatrist, or psychologist reflecting the nature and extent of the disability or disabilities that cause such person to qualify as a person with a significant disability. ***Or*** a state vocational agency certification listing the disability or disabilities that cause such person to qualify as a person with a significant disability.	
	3. Data Sheet	Demographic and contact information	8-9
	4. Comprehensive Release Forms	Includes permission for emergency care, release of information, human rights statement, and authorized team member release	10-11
	5. Self Reporting Medical	Provides medical status overview	12-13
	6. General Assessment Form	States Employment Desires	14-15
	7. Privacy Practices Acknowledgement Form	Signature confirms that the privacy practices were received	21
	8. Privacy Practices	Applicant copy of privacy practices	22-27
The following are required for Individual Supported Employment Only			
	9. Data for Employment Success	Explores employment interests and strengths	16-17
	10. Barrier Checklist	Identifies and addresses potential barriers to attaining and maintaining employment	18
	11. Individual Plan for Employment	Discusses roles and responsibilities of ServiceSource and individual served to attain and maintain employment – to be completed with ServiceSource employment staff	19-20

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SERVICESOURCE REFERRAL FORM

Referring Agency: _____

Proposed Funding (check one): ____Medicaid Waiver ____Local CSB ____DRS ____DORS ____Not sure

Referral Agency Address: _____

Contact Person: _____

Contact Phone: _____

Person Referred: _____

Address: _____

_____

Reason for Referral: _____

Please check one of the following to indicate the initial program offering to which you are referring the above named individual:

Center Based Program Offerings

√	Program Offering	Description
	Day Support	A center based program offering intensive support ratios designed to assist individuals with multiple disabilities build necessary skills for employment
	Employment Resource Center	A program offering employment placement, community integration, educational and other services.

Community Based Program Offerings

√	Program Offering	Description
	Group Supported Employment	Five to eight consumers work under continuous supervision by ServiceSource staff within a "host" company in the community.
	Individual Placement	This service covers an array of options including ***situational assessments, job development, job coaching, travel training, and long-term retention services.***
	Commercial and Government Contracts Division	Employment in mailrooms, shipping and receiving, commissaries, food service operations, administrative and clerical support, etc.
	Information Technology Training	Free tuition to Fairfax County residents with disabilities for an 18-week Technology Training program and placement support upon completion, in partnership with the Laurie Mitchell Employment Center.
	Laurie Mitchell Self Help Employment Center	A consumer operated employment center that provides career support, training, and information to persons with disabilities.

Please send referrals to:

Sylvia McGill
ServiceSource
10467 White Granite Drive
Oakton VA, 22124
Phone: 703-970-3697
Fax: 703-352- 1790
Email: Sylvia.McGill-Jones@servicesource.org

Thank You for Your Referral!

ServiceSource DATA SHEET – The information on this form is required for participation in ServiceSource's rehabilitation program. The information is ***confidential*** and is not reviewed when making employment decisions.

First Name:_____

Last Name:_____

Social Security Number: _____/_____/_____ Birthdate: _____/_____/_____

Street Address:_____

City: _____ State: _____

Zip code:_____

Home phone: ( )_____ _____ _____ - _____ _____ _____ _____

Work phone: ( )_____ _____ _____ - _____ _____ _____ _____

E-mail address:_____

Residential Arrangement (check one):

- ❑ Live with self
- ❑ Live with family
- ❑ Live in group home (specify:_____)
- ❑ Live in supervised apt (specify:_____)
- ❑ Other

Benefits (check all that apply):

Type: Mos. Amount

- ❑ SSI $_____ _____
- ❑ SSDI $_____
- ❑ SSDI & SSI $_____
- ❑ Other $_____
- ❑ Interested in benefits counseling to understand how working may interact with your benefits?

Medical Information

Date of last physical exam _____/_____/_____

Primary Health Insurance:

_____

Secondary Health Insurance:

Medicaid Number (if applicable):

_____

For statistical purposes only:

Sex

- ❑ Male
- ❑ Female

Ethnicity

- ❑ American Indian
- ❑ Black/African American
- ❑ Caucasian
- ❑ Hispanic/Latino
- ❑ Asian
- ❑ Two or more ethnicities/races
- ❑ Other_____

Check all "yes" responses:

- ❑ Are you a veteran? If yes:
- ❑ Did you serve in Vietnam?
- ❑ Did you serve in Iraq or Afghanistan?
- ❑ Do you have a military disability?
- ❑ Are you a US citizen?

Emergency Contacts

Please be sure to include any members of an individual's support team - mental health therapist, case manager, psychiatrist, community support worker, family member, friend, etc. - at **least one emergency contact,** legal guardians (court appointed), residential staff and primary care physician if applicable.

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone ( ) ____ _____ _____-____ ____ ____ _____

Work Phone ( ) ____ _____ _____-____ ____ ____ _____ ext.:_____

E-mail address: _____

*Check here if legal guardian_____ **Check here if Authorized Representative____

Type of contact:
____Parent _____Sibling _____Therapist _____Support Coordinator/Case manager
____Residential staff _____ Other:_____

* Legal guardian refers to a court adjudicated legal guardian
** Authorized representative refers to an individual that is authorized to receive and share information regarding your employment and rehabilitative services. An Auth Rep release must be in service file

Emergency Contacts (addl. contacts on page 2):

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone ( ) ____ _____ _____-____ ____ ____ _____

Work Phone ( ) ____ _____ _____-____ ____ ____ _____ ext.:_____

E-mail address: _____

*Check here if legal guardian_____ **Check here if Authorized Representative____

Type of contact:
____Parent _____Sibling _____Therapist _____Support Coordinator/Case manager
____Residential staff _____ Other:_____

* Legal guardian refers to a court adjudicated legal guardian
** Authorized representative refers to an individual that is authorized to receive and share information regarding your employment and rehabilitative services. An Auth Rep release must be in service file

Emergency Contacts: Name_____ Address_____ City_____ State_____ Zip_____ Home Phone ( ) ____ _____ _____-____ ____ ____ _____ Work Phone ( ) ____ _____ _____-____ ____ ____ _____ ext.:_____ E-mail address: _____ Check here if legal guardian:_____ **Check here if Authorized Representative:____ Type of contact: ____Parent _____Sibling _____Therapist _____Support Coordinator/Case manager ____Residential staff _____ Other:_____ * Legal guardian refers to a court adjudicated legal guardian ** Authorized representative refers to an individual that is authorized to receive and share information regarding	**Emergency Contacts:** Name_____ Address_____ City_____ State_____ Zip_____ Home Phone ( ) ____ _____ _____-____ ____ ____ _____ Work Phone ( ) ____ _____ _____-____ ____ ____ _____ ext.:_____ E-mail address: _____ Check here if legal guardian:_____ **Check here if Authorized Representative:____ Type of contact: ____Parent _____Sibling _____Therapist _____Support Coordinator/Case manager ____Residential staff _____ Other::_____ * Legal guardian refers to a court adjudicated legal guardian ** Authorized representative refers to an individual that is authorized to receive and share information regarding

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COMPREHENSIVE RELEASE FORM

Name required for release to be valid
All Releases below pertain to (List Participant name): _____

AUTHORIZED TEAM MEMBER RELEASE

We encourage program participants to include an interested family member, friend, or associate in your program development and review process. An authorized team member is a person chosen by you, who you may wish to help you understand important information about employment or rehabilitation services provided to you by ServiceSource.

☐I (above mentioned participant) do not appoint anyone to act as my Authorized Team Member at this time.

☐ I (above mentioned participant) appoint _____ to act as my Authorized Team Member. I hereby permit ServiceSource, Inc. and my Authorized Team Member to exchange information regarding the following activities for the purpose(s) listed below. I understand that the information will be used for professional purposes only.

- Participate in Individual Program Plan Meetings
- Participate in Interdisciplinary Team Meetings
- Receipt of general and specific program information, including program plan reports and general organizational information
- Human Resources Information such as explanation of benefits
- Emergency contacts

My Authorized Team Member can be contacted at the following address and phone number (Please Print):

Name:_____

Street Address:_____

City/State/Zip: _____

Phone (home): (_____)_____
Phone (work): (_____)_____

_____ _____
Participant Date

_____ _____
Authorized Team Member or Guardian Date

RELEASE OF INFORMATION

I, *(above named participant)*, hereby authorize ServiceSource, Inc. to release information to /or obtain information from: (Check all that apply)

☐ Provider(s) of Funding: _____ [☐ verbal /☐ written]
☐ CSB/Therapist/Support Coordinator [☐ verbal / ☐ written]
☐ DARS/DRS [☐ verbal / ☐ written]
☐ Residential Provider [☐ verbal / ☐ written]
☐ Doctor [☐ verbal / ☐ written]
☐ Social Security [☐ verbal / ☐ written]
☐ Family Members/Friends (please specify):
_____[☐ verbal / ☐ written]
☒ Compliance Surveyors (CARF, DBHDS/DMAS, SourceAmerica, DOL, Maximus, and/or other federal compliance agencies)
☐ Other _____[☐ verbal / ☐ written]
☐ Other _____[☐ verbal / ☐ written]
☐ Other _____[☐ verbal / ☐ written]

I understand that the information will be used for professional purposes only and will be limited to the following information: (Check all that apply)

☒ Vocational Evaluation
☒ Psychological Reports
☒ Individual Program Plans
☒ Medical Reports
☒ Social History
☒ Progress Reports

This purpose of this release is to:
☒ Coordinate vocational/rehabilitation program
☒ Verification of employment (salary, dates of employment, title, social security number)
☒ Verify compliance with internal and external regulations
☐ Other, specify:_____

_____ _____
Participant Date

_____ _____
Authorized Team Member or Guardian Date

ALL RELEASES VALID FOR ONE YEAR FROM DATE SIGNED UNLESS RESCINDED BY PARTICIPANT

From revised 5/25/04

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COMPRENSIVE RELEASE FORM

Name required for release to be valid
All Releases below pertain to (List Participant name): _____

HUMAN RIGHTS STATEMENT

As a person being served by ServiceSource or affiliate agency, you have the rights that are protected by government regulations. No one may take away your rights, except in rare special cases.

The following is a summary of these rights. If you need help in understanding them or how they apply to you, please contact a staff member.

You have the following rights:

- **To be treated with dignity and respect**
- **To receive services regardless of race, religion, sex, disability, national origin, age or ability to pay.**
- **To receive help in the development of your treatment or program plan**
- **To privacy**
- **To confidential handling of records**
- **To be protected from harm and abuse**
- **To receive services in a safe and clean place**
- **To ask questions and get help with your rights**
- **To have your complaints resolved**
- **To review the Human Rights Plan of your Community Services Board**
- **To receive fair pay for work done**

In addition as a person living in a residential setting you have the right:

- **To clean suitable clothing**
- **To speak by phone or write letters to anyone (and to be helped if you need it) unless your treatment or program plan limits this**
- **To talk in private with any court appointed representative Human Rights Consultant**
- **To attend or not attend any religious services held on the premises and to practice your religion**
- **To be paid for work that you do which is not part of your treatment program or plan**.

If you believe your rights have been taken away, you may follow these steps:

Call or write the agency supervisor or program director with your complaint;
If your complaint is unresolved, you may ask for a formal hearing. Staff will tell you how to submit the request.
<u>For Virginia Day Support Only</u>: Call your Human rights Advocate, at (804) 305-0461. The advocate makes sure the rights of consumers in community programs are respected.

Human Rights Acknowledgment
I have received a written/verbal summary of my rights as a consumer of ServiceSource or affiliate agency.

_____ _____
Participant Date

_____ _____
Authorized Team Member or Guardian Date

PERMISSION FOR EMERGENCY CARE

ServiceSource, Inc. has permission in an emergency to take (*above named participant*) to the emergency room of a hospital for the purpose of receiving the medical or surgical treatment that may be deemed necessary by the emergency room physician.

_____ _____
Participant Date

_____ _____
Authorized Team Member or Guardian Date

ALL RELEASES VALID FOR ONE YEAR FROM DATE SIGNED UNLESS RESCINDED BY PARTICIPANT

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PROGRAM PARTICIPANT SELF REPORTING MEDICAL

Participant's Name: _____ Date Information Provided: _____

A complete update of this report is required annually

State licensure requires that ServiceSource keep complete and regularly updated medical information for emergency medical purposes. Accordingly, a complete **annual update** is required to begin and continue participation in the ServiceSource rehabilitation and employment program. This information is used for medical monitoring and is not viewed by ServiceSource hiring managers.

Primary Care Physician contact information (required):

Name: _____
Address: _____

_____

Telephone: ( ) _____

Psychiatrist (if applicable):

Name: _____
Address: _____

_____

Telephone: ( ) _____

Do you have a lifting restriction as directed by a physician?
☐**NO** ☐**Yes (Maximum limit)___lbs**

Do you have any limitations and/or restrictions on physical activities? ☐**NO** ☐**Yes (please list):**

_____

_____

Do you have any recent physical complaints and medical conditions? ☐**NO** ☐**Yes (please list):**

_____

_____

Have you had any major illness, injuries, trauma and/or operations/hospitalizations that medical personnel need to know about in the event of an emergency? ☐**No** ☐**Yes (please list):**

_____

_____

Are you currently taking Prescription or Non-Prescription Medications? ☐**NO** ☐**Yes (please list):**
If yes, can you self-medicate? ☐**NO** ☐**Yes** ☐**N/A**

Medication Name _____	Medication Name _____	Medication Name _____
Dosage (mg) _____	Dosage (mg) _____	Dosage (mg) _____
Frequency _____	Frequency _____	Frequency _____
Date prescribed _____	Date prescribed _____	Date prescribed _____
Reason prescribed _____	Reason prescribed _____	Reason prescribed _____
Medication Name _____	Medication Name _____	Medication Name _____
Dosage (mg) _____	Dosage (mg) _____	Dosage (mg) _____
Frequency _____	Frequency _____	Frequency _____
Date prescribed _____	Date prescribed _____	Date prescribed _____
Reason prescribed _____	Reason prescribed _____	Reason prescribed _____

Please attach additional sheet of paper if you need to list more medications.

Please Also Complete Page 2

Participant's Name: _____ Date Information Provided: _____

Do you have or have you ever had any of the following medical conditions or chronic illnesses which ServiceSource should be aware of for making work or program assignments, providing reasonable accommodations, or in the event of an emergency? (Check all that apply):

		Condition:	Comments/Relevant Information:
☐No	☐Yes	Allergies	
☐No	☐Yes	Ambulatory (Movement) or Sensory Prob.	
☐No	☐Yes	Arthritis	
☐No	☐Yes	Asthma	
☐No	☐Yes	Back Conditions	
☐No	☐Yes	Cancer	
☐No	☐Yes	Diabetes	
☐No	☐Yes	Ear, Nose, Throat Trouble	
☐No	☐Yes	Emphysema/Lung Disorders	
☐No	☐Yes	Epilepsy or Seizure Disorder	
☐No	☐Yes	Heart Condition	
☐No	☐Yes	Hepatitis	
☐No	☐Yes	High Blood Pressure	
☐No	☐Yes	HIV or Related Conditions	
☐No	☐Yes	Knee or Leg Issues	
☐No	☐Yes	Kidney Disease	
☐No	☐Yes	Mental Health Diagnoses	
☐No	☐Yes	Severe Headaches	
☐No	☐Yes	Stomach / Intestinal Problems	
☐No	☐Yes	Substance Use Diagnoses	
☐No	☐Yes	Tuberculosis	
☐No	☐Yes	Wear Glasses/Contacts	
☐No	☐Yes	Any other chronic conditions	
☐No	☐Yes	Any other communicable diseases	
☐No	☐Yes	Other:	

Please share any information about current nutritional needs:

_____

_____

Please share any information about past serious illness and chronic conditions of your parents, siblings, and significant others in your household:

_____

_____

Form Completed by/Relationship: _____

Last Form Update 12/2017

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GENERAL ASSESSMENT FORM

❑ Self-Report	❑ Face to Face Interview

Program Participant Name: _____Conducted By (ServiceSource Staff Name): _____

Please answer the following questions:

1. Are you still in need of placement services?

   ❑ Yes, I am not working now. ❑ Yes, I am working, but want to change jobs. ❑ No

2. I am willing to work (check all that apply):

   ❑ Weekends ❑ Evenings ❑ Part-time ❑ Full-time ❑ Varied shifts

3. I am willing to work in the following areas (please list any cities, states, etc. – Cities in Virginia, Maryland; Washington, DC):

   _____

4. What is most important in a job for you? (please select your top 3)

   ❑ Advancement/Training Opportunities
   ❑ Location
   ❑ Benefits
   ❑ Pleasant Environment
   ❑ Enjoyable Tasks
   ❑ Staying busy
   ❑ Money
   ❑ Transportation
   ❑ Flexible Schedule
   ❑ Other: _____

5. Please check all job categories that apply:

	Are you interested in doing this type of work?		*Do you have experience in this field?*			*Are you interested in doing this type of work?*		*Do you have experience in this field?*	
Mailroom	❑ Yes	❑ No	❑ Yes	❑ No	Janitorial	❑ Yes	❑ No	❑ Yes	❑ No
Office Support	❑ Yes	❑ No	❑ Yes	❑ No	Shipping/Receiving	❑ Yes	❑ No	❑ Yes	❑ No
Food Service	❑ Yes	❑ No	❑ Yes	❑ No	Retail/Stocking	❑ Yes	❑ No	❑ Yes	❑ No
Digital Scanning/ Prep/Data Entry	❑ Yes	❑ No	❑ Yes	❑ No	Maintenance	❑ Yes	❑ No	❑ Yes	❑ No
Electronics Recycling	❑ Yes	❑ No	❑ Yes	❑ No	Other:	❑ Yes	❑ No	❑ Yes	❑ No

6. Please share any other types of jobs in which you are interested: _____

7. What was your longest job held? _____

   ❑ Less than 6 months ❑ 6 months-1 year ❑ 1-2 years ❑ 2 or more years

8. Do you have a driver's license?

   ❑ Yes ❑ No

9. How would you get to work?

   ❑ No transportation ❑ Use specialized transportation services (MetroAccess, Fastran, etc.) ❑ Use public transportation ❑ Family will transport ❑ Provide own (Car, walk, bike, etc.)

10. Do you need help accessing transportation?

- ❑ Need bus and/or metro rail training*
- ❑ Need assistance with route planning
- ❑ Use bus and/or metro rail independently
- ❑ Make own travel arrangements

11. How much can you lift?

- ❑ 4-9 pounds
- ❑ 10-25 pounds
- ❑ 26-50 pounds
- ❑ More than 50 pounds

12. How well can you read? (Check one)

- ❑ Cannot read
- ❑ Sight words
- ❑ Simple reading
- ❑ Fluent reading

13. Tell us about any financial ramifications to employment: (Check the one which is most appropriate)

- ❑ Need a part-time job to avoid loss of benefits
- ❑ Need a job with benefits
- ❑ No financial concerns

14. Tell us about your office support skills:

- ❑ Typing: How many words per minute? _____
- ❑ Alphabetical Filing
- ❑ Numerical Filing
- ❑ Answering phones
- ❑ Transferring Calls
- ❑ Copy machines
- ❑ Fax machines

15. Tell us about your money skills (Check one):

- ❑ Count Money
- ❑ Know value of coins and bills
- ❑ Recognizes coins/bills only
- ❑ None

16. Do you know how to operate a computer?

- ❑ Yes
- ❑ No

17. Are you proficient in (check all that apply)?

- ❑ Word-processing? (Word, etc.)
- ❑ Spreadsheets? (Excel, etc.)
- ❑ Publishing/Graphics? (Adobe InDesign, Publisher, etc.)
- ❑ Presentations? (PowerPoint, etc.)
- ❑ Databases? (Access, etc.)
- ❑ Other: _____

18. Tell us about your physical abilities (check all that apply):

- ❑ Have full physical abilities
- ❑ Have hearing limitations
- ❑ Have visual limitations
- ❑ Have limitations with manual dexterity
- ❑ Fair movement w/ stairs & minor obstacles
- ❑ Challenges to movement, i.e. need to sit/stand in one area
- ❑ Other limitations: _____ _____ _____

19. What other skills/preferences/information/accommodations should ServiceSource know about?

*__For the DC Metro Region Only:__ Please contact WMATA or Endependence Center for travel training workshop. Provide information about the Reduced Fare program through WMATA to ride the bus and metro at a lower rate.

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Data for Employment Success

1) General Information:

- Name: _____
- Legally authorized to work in the United States: □ Yes □ No
- Paper: □ Resume □ Cover letters □ Certifications

2) Education:

- High school? □ Yes □ No Years_____ □ GED
- College/University? □ Yes □ No How many years? _____

  Graduated? □ Yes □ No

  Degree: □ BA □ BS □ Assoc. Deg. □ MS □ PhD

  Major of Study: _____

- Other education: _____

  _____

3) **Skills/Abilities:**

- Languages (other than English): □ Yes □ No
  - _____: □ Reading □ Writing □ Speech □ Fluent
  - _____: □ Reading □ Writing □ Speech □ Fluent
  - _____: □ Reading □ Writing □ Speech □ Fluent
- Technical/Electrical: □ Yes: _____ □ No
- Crafts: □ Yes: _____ □ No

4) <u>Work Environment</u>:

- Pay: □ $<10 □ $10-15 □ $15-20 □ $>20 □ Other: $_____

  □ < 20K □ 20k-30k □30k-50k □>50k □ Other: $_____

- Category: □ ACCT □ Admin. □ Pharm. □ Social Services □ Education

  □ CS/IT □ Clerical □ HR □ Customer Service □ Sales

  □ Security □ Food □ Trades □ _____

- Location: □ DC □ MD □ VA-RE/HE □ VA-AL/AR □ VIE/MCL

  □ VA-FX □ VA-PWC □ Other: _____

- Comments: _____

  _____

  _____

5) <u>Experiences</u>: (Please use if individual does not have a resume)

a) Company Name: _____ How long: _____

Title: _____

Income: _____ Hours per Week: _____

Duties:_____

_____

_____

b) Company Name: _____ How long: _____

Title: _____

Income: _____ Hours per Week: _____

Duties:_____

_____

_____

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Barrier Checklist

Please address the following potential barriers during the intake meeting. This information is confidential and not shared with any potential or actual employers.

			Description of Barrier
☐ Yes	☐ No	☐ N/A	1) Do you have any concerns about reliable child care?
☐ Yes	☐ No	☐ N/A	2) Do you have concerns about reliable transportation?
☐ Yes	☐ No	☐ N/A	3) Do you have any concerns about professional clothing for interviews?
☐ Yes	☐ No	☐ N/A	4) Do you have any concerns about passing a credit check?
☐ Yes	☐ No	☐ N/A	5) Do you have any concerns about stable housing?
☐ Yes	☐ No	☐ N/A	6) Do you have a legal history? If so, please list convictions: _____
☐ Yes	☐ No	☐ N/A	7) Do you have any concerns about having I9 Documentation to complete new hire paperwork? (Passport OR State Picture ID and Social Security Card/Birth Certificate)
☐ Yes	☐ No	☐ N/A	8) Other: _____

Comments (if any) about barriers above and Plan to resolve barriers:

_____
_____
_____
_____
_____
_____
_____

Participant Name _____ Date _____

ServiceSource
A LEADING RESOURCE FOR PEOPLE WITH DISABILITIES

Individual Plan for Employment (IPE)

This document should be reviewed with companion *General Assessment Form*

General Information:

Name (Last, First Middle)	Source Rehab ID #
Employment Development Specialist Name	Phone #
Other Involved Agency or Person (i.e. DARS, CSB, etc.)	Phone #

Employment Outcome Desired:

Check All That Apply:	Notes Regarding Employment Outcome Desired (Please state specific interests for career fields, positions, and employers, PT/FT schedule, days/shifts willing to work, location, wage, etc.):
❑ Obtain Full Time Employment ❑ Retain Full Time Employment ❑ Obtain Part Time Employment ❑ Retain Part Time Employment ❑ Obtain Supported Employment ❑ Obtain Self Employment	

Supportive Services Needed to Achieve Outcome:

Check All That Apply:	Notes Regarding Supportive Services Needed. Please Specify Provider Of Support::
❑ Assistive Technology ❑ Personal Assistance Services ❑ Job Development Support ❑ Job Coaching Support ❑ Education and Training ❑ Benefits Counseling ❑ Other_____	

Timeframes:

Date This Plan Was Developed: ____/____/____

Date Initial Service Will Begin: ___/____/____

Estimated Date Outcome Will Be Achieved: ___/___/_____ *Note: This Plan Must Be Reviewed At Least Annually To Assess Progress*

Ongoing Employment Services Anticipated:

Check All That Apply:	Notes Regarding Ongoing Employment Services Anticipated. Be Specific About Provider of Ongoing Employment Service That Will Be Sought:
❑ Follow Along Employment Support ❑ Mental Health Counseling (CSB, private, etc.) ❑ Case Management (CSB, private, etc.) ❑ Benefits counseling ❑ Community Support Services ❑ Other_____	

General Responsibilities:

Role of ServiceSource Employ. Dev. Spec.:	Role of Customer:
Role in Obtaining Employment:	Role in Obtaining Employment:
Role in Retaining Employment:	Role in Retaining Employment:

Signatures:

Signature of ServiceSource EDS:	Signature of Customer:	Signature of Guardian/Authorized Representative:
Signature	Signature	Signature
Date	Date	Date

Compliance Representative
10467 White Granite Drive
Oakton VA, 22124
(703) 461-6000

Acknowledgment of Receipt of Notice of Privacy Practices

This is to acknowledge my receipt of the Notice of Privacy Practices (effective date April 14, 2003) on the date stated below.

_____
Date of Individual's or Personal Representative's Signature

_____
Signature of Individual or Personal Representative

_____
Individual's Name

_____

_____
Individual's Address

_____
Program

_____
Name of Personal Representative (If applicable)

_____

_____
Description of Representative's Authority to Act for the Individual (If applicable)

NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003

This notice describes how information about you may be used and disclosed and how you can get access to this information.

Please review it carefully and sign the acknowledgement of the notice.
Thank you.

Compliance
Representative:
10467 White Granite Drive
Oakton VA, 22124
(703) 461-6000

This notice will tell you how we may use and disclose protected health information about you. Protected health information means any information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you.

This notice also will tell you about your rights and our duties with respect to health information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights.

The federal government identifies the services we provide to you as "health care" and our services that we provide to you as "treatment." Therefore, the information we have about you is protected. As you read through this notice, you will see that not everything may apply to you and our relationship to you as a provider of services. This notice is given to outline all Privacy Practices developed by our organization.

How We May Use and Disclose Health Information About You.

We use and disclose health information about you for a number of different purposes. Each of those purposes is described below.

For Treatment.

We may use health information about you to provide, coordinate or manage the services and supports you receive from us and other providers. We may disclose health information about you to direct support staff and other agency staff, volunteers and other persons who are involved in supporting you or providing services. We may consult with other providers concerning you and, as part of the consultation, share your health information with them. For example, staff may discuss your information to develop and carry out your individual service plan. Staff may share information to coordinate needed services, such as testing, training, transportation, etc. Staff may need to disclose health information to entities outside of our organization (for example, another provider or a state/local agency) to obtain new services for you.

For Payment.

We may use and disclose health information about you so we can be paid for the services we provide to you. This can include billing a third party payer, such as Medicare or other governmental agency or your insurance company. We also may need to provide information to a governmental agency ensure you are eligible for services.

For Health Care Operations.

We may use and disclose health information about you for our own operations. These are necessary for us to operate and to maintain quality for our customers. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization, for accreditation or licensing activities, or for our compliance program.

How We Will Contact You.

Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your workplace. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see “Right to Receive Confidential Communications” on page 11 of this Notice.

Treatment and Service Alternatives.

We may use and disclose health information about you to contact you about treatment and service alternatives that may be of interest to you.

Health Related Benefits and Services.

We may use and disclose health information about you to contact you about health-related benefits and services that may be of interest to you.

Marketing Communications.

We may use and disclose health information about you to communicate with you about a product or service to encourage you to purchase the product or service. This may be:

To describe a health-related product or service that is provided by us;

For your treatment;

For case management or care coordination for you;

To direct or recommend alternative treatments, therapies, health care providers, or settings of care.

We may communicate to you about products and services in a face-to-face communication by us to you. We also may communicate about products or services in the form of a promotional gift of nominal value.

All other use and disclosure of health information about you by us to make a communication about a product or service to encourage the purchase or use of a product or service will be done only with your written authorization.

Fundraising.

We may use and disclose health information about you to raise funds for our organization. We may disclose health information to a foundation related to our organization so that the foundation may contact you to raise money for the benefit of our programs. We will only release demographic information, such as your name and address, and the dates you received services. If you do not want us or a related foundation to contact you for fundraising, you must notify your designated Compliance Representative in writing.

Directory.

We may include your name and your location in our facility in a directory while you receive services. This information may be released to people who ask for you by name. If you do not want to be included in our facility directory, or you want to restrict the information we include in the directory, you must notify your designated Compliance Representative of your objection.

Disclosures to Family and Others.

We may disclose to a parent/guardian, personal representative, family member, other relative, a close personal friend, or any other person identified by you, health information about you that is directly relevant to that person’s involvement with the services and supports you receive or payment for those services and supports. We also may use or disclose health information about you to notify, or assist in notifying, those persons of your location, general condition, or death. If there is a family member, other relative, or close personal friend that you do not want us to disclose health information about you to, please notify your designated Compliance Representative.

Disaster Relief.

We may use or disclose health information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be done to coordinate with those entities in notifying a parent/guardian, personal representative, family member, other relative, close personal friend, or other person identified by you of your location, general condition, or death.

Required by Law.

We may use or disclose health information about you when we are required to do so by law.

Public Health Activities.

We may disclose health information about you for public health activities and purposes. This includes reporting health information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease. Or, one that is authorized to receive reports of child abuse and neglect. It also includes reporting for purposes of activities related to the quality, safety or effectiveness of a United States Food and Drug administration regulated product or activity.

Victims of Abuse, Neglect or Domestic Violence.

We may disclose health information about you to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe you are a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by you or your personal representative; or, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims, or, if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities.

We may disclose health information about you to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations.

Judicial and Administrative Proceedings.

We may disclose health information about you in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal. We also may disclose health information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes.

We may disclose health information about you to a law enforcement official for law enforcement purposes:

a. As required by law.

b. In response to a court, grand jury or administrative order, warrant or subpoena.

c. To identify or locate a suspect, fugitive, material witness or missing person.

d. About an actual or suspected victim of a crime and that person agrees to the disclosure. If we are unable to obtain that person's agreement, in limited circumstances, the information may still be disclosed.

e. To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct.

f. About crimes that occur at our facility.

g. To report a crime in emergency circumstances.

Research.

Under certain circumstances, we may use or disclose health information about you for research. Before we disclose health information for research, the research will have been approved through an approval process that evaluates the needs of the research project with your needs for privacy of your health information. We may, however, disclose health information about you to a person employed by us who is preparing to conduct research to permit them to prepare for the project, but no health information will leave our organization during that person's review of the information.

To Avert Serious Threat to Health or Safety.

We may use or disclose protected health information about you if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We also may release information about you if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

Military.

If you are a member of the Armed Forces, we may use and disclose health information about you for activities deemed necessary by the appropriate military command authorities to assure the proper execution of the military mission. We may also release information about foreign military personnel to the appropriate foreign military authority for the same purposes.

National Security and Intelligence.

We may disclose health information about you to authorized federal officials for the conduct of intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President.

We may disclose health information about you to authorized federal officials so they can provide protection to the President of the United States, certain other federal officials, or foreign heads of state.

Security Clearances.

We may use health information about you to make medical suitability determinations and may disclose the results to officials in the United States Department of State for purposes of a required security clearance or service abroad.

Inmates; Persons in Custody.

We may disclose health information about you to a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care to you; (b) for the health and safety of others; or, (c) the safety, security, and good order of the correctional institution.

Workers Compensation.

We may disclose health information about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Other Uses and Disclosures.

Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying your designated Compliance Representative in writing of your desire to revoke it. However, if you revoke such an authorization, it will not have any affect on actions taken by us in reliance on it.

Your Rights With Respect to Health Information About You.

You have the following rights with respect to health information that we maintain about you.

Right to Request Restrictions.

You have the right to request that we restrict the uses or disclosures of health information about you to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member, other relative, a close personal friend or any other person identified by you; or, (b) public or private entities for disaster relief efforts. For example, you could ask that we not disclose health information about you to your brother or sister.

To request a restriction, you may do so at any time. If you request a restriction, you should do so to your Compliance Representative and tell us: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and, (c) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction.

Right to Receive Confidential Communications.

You have the right to request that we communicate health information about you to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication.

If you want to request confidential communication, you must do so in writing to your Compliance Representative. Your request must state how or where you can be contacted.

We will accommodate your request. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

Right to Inspect and Copy.

With a few very limited exceptions, such as psychotherapy notes, you have the right to inspect and obtain a copy of health information about you.

To inspect or copy health information about you, you must submit your request in writing to your Compliance Representative. Your request should state specifically what health information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

We will act on your request within thirty (30) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

We may deny your request to inspect and copy health information if the health information involved is:

a. Psychotherapy notes;

b. Information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding;

If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed, and how you may complain. If you request a review of our denial, it will be conducted by a licensed health care professional designed by us who was not directly involved in the denial. We will comply with the outcome of that review.

Right to Amend.

You have the right to ask us to amend health information about you. You have this right for so long as the health information is maintained by us.

To request an amendment, you must submit your request in writing to your Compliance Representative. Your request must state the amendment desired and provide a reason in support of that amendment.

> We will act on your request within sixty (60) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

If we grant the request, in whole or in part, we will seek your identification of and agreement to share the amendment with relevant other persons. We also will make the appropriate amendment to the health information by appending or otherwise providing a link to the amendment.

We may deny your request to amend health information about you. We may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, we may deny your request to amend health information if we determine that the information:

a. Was not created by us, unless the person or entity that created the information is no longer available to act on the requested amendment;

b. Is not part of the health information maintained by us;

c. Would not be available for you to inspect or copy; or,

d. Is accurate and complete.

If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreeing with our denial. Your statement may not exceed 2 pages. We may prepare a rebuttal to that statement. Your request for amendment, our denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the health information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of any of that information.

If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the health information involved.

You also will have the right to complain about our denial of your request.

Right to an Accounting of Disclosures.

You have the right to receive an accounting of disclosures of health information about you. The accounting may be for up to six (6) years prior to the date on which you request the accounting but not before April 14, 2003.

Certain types of disclosures are not included in such an accounting:

a. Disclosures to carry out treatment, payment, and health care operations;

b. Disclosures of your health information made to you;

c. Disclosures that are incident to another use or disclosure;

d. Disclosures that you have authorized;

e. Disclosures for our facility directory or to persons involved in your care;

f. Disclosures for disaster relief purposes;

g. Disclosures for national security or intelligence purposes;

h. Disclosures to correctional institutions or law enforcement officials;

i. Disclosures that are part of a limited data set for purposes of research, public health, or health care operations (a limited data set is where things that would directly identify you have been removed).

j. Disclosures made prior to April 14, 2003.

Under certain circumstances your right to an accounting of disclosures to a law enforcement official or a health oversight agency may be suspended. Should you request an accounting during the period of time your right is suspended, the accounting would not include the disclosure or disclosures to a law enforcement official or to a health oversight agency.

To request an accounting of disclosures, you must submit your request in writing to ___your Compliance Representative. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request and may not include dates before April 14, 2003.

Usually, we will act on your request within sixty (60) calendar days after we receive your request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary.

There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

Right to Copy of this Notice.

You have the right to obtain a paper copy of our Notice of Privacy Practices. You may obtain a paper copy even though you agreed to receive the notice electronically. You may request a copy of our Notice of Privacy Practices at any time.

You may obtain a copy of our Notice of Privacy Practices over the Internet at our web site, www.servicesource.org.

To obtain a paper copy of this notice, contact your Compliance Representative.

Our Duties Generally.

We are required by law to maintain the privacy of health information about you and to provide individuals with notice of our legal duties and privacy practices with respect to health information.

We are required to abide by the terms of our Notice of Privacy Practices in effect at the time.

Our Right to Change Notice of Privacy Practices.

We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the new notice's provisions effective for all health information that we maintain, including that created or received by us prior to the effective date of the new notice.

Availability of Notice of Privacy Practices.

A copy of our current Notice of Privacy Practices will be posted on Bulletin Boards located in service areas. A copy of the current notice also will be posted on our web site, www.servicesource.org

At any time, you may obtain a copy of the current Notice of Privacy Practices by contacting your Compliance Representative.

Effective Date of Notice.

The effective date of the notice will be stated on the first page of the notice.

Complaints.

You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

To file a complaint with us, contact your Compliance Representative. All complaints should be submitted in writing.

To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him or her in care of: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201.

You will not be retaliated against for filing a complaint.

Questions and Information.

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact your Compliance Representative