UPMC Jameson

Name:	**Date of Birth:**	**Current Age:**
Address: **Street:** _____ **City:** _____ **Zip Code:** _____	**Date of your 22nd birthday:** **Social Security #:** **Cell Number:** **Email:**	
Transition Coordinator:	**Coordinator's Email Address:**	

Parent/Guardian Information	
Parent/Guardian 1:	**Home Phone:**
	Cell Phone:
Parent/Guardian 2:	**Home Phone:**
	Cell Phone:

Legal Guardian Information		
Are you your own guardian: **If no, please attach court documents*	☐ **YES**	☐ **NO**

Educational Background		
Your School District/Attending School: **Number of absences this year:**		
Will you continue transition focused programming beyond high school graduation?	☐ **YES**	☐ **NO**
Will you have all credits necessary to meet graduation requirements at the end of this academic year?	☐ **YES**	☐ **NO**
Have you ever been placed on a behavioral plan while in high school? **If yes, please attach to the application with any supporting documentation.**	☐ **YES**	☐ **NO**
Have you ever been suspended or removed from high school or from any other program (e.g., summer camp)? **If yes, please describe:**	☐ **YES**	☐ **NO**
Have you deferred your high school diploma/graduation?	☐ **YES**	☐ **NO**
Do you have all your credits necessary to graduate? **Include Transcripts*	☐ **YES**	☐ **NO**

Have you ever worked with a teacher's aide/paraprofessional?	☐ **in school:**	☐ **in the community:**
If yes, when was the last time:		
How often have you worked with him/her:		

Other than public education, have you received any additional formal job or vocational training? **If yes, describe and list date and location of the training:**	☐ **YES**	☐ **NO**

Employment Background:		
Do you plan to pursue entry level employment in the community after graduation from Project SEARCH? **If so, what kind of work do you want to do?**	☐ **YES**	☐ **NO**
Do you want to work full-time or part-time? ☐ **Full time**	☐ **Part Time: how many hours: _____**	
Do you plan to work during the school year outside of Project SEARCH? **If yes, where?** **How many hours per week?**	☐ **YES**	☐ **NO**
Did you receive job coaching or other support in previous paid jobs? **If yes, how many hours of job coaching per week and for what length of time?** **If yes, what type of work supports and/or coaching were needed?**	☐ **YES**	☐ **NO**
Have you obtained any previous jobs without assistance? **If yes, where?**	☐ **YES**	☐ **NO**
Have you ever quit a job? **If yes, why?**	☐ **YES**	☐ **NO**
Have you ever been fired from a job? **If yes, why?**	☐ **YES**	☐ **NO**
Have you ever been involved in the court system? **If yes, please explain:**	☐ **YES**	☐ **NO**
List any specific disability-related accommodations requested for purposes of Project SEARCH:		

 Client Name: _____

Please list information below regarding unpaid and volunteer work experiences that you have participated in during the past three years:

Unpaid Work Experiences					
Location	**Job Duties**	**Hours /Week**	**Supervisor**	**Phone #**	**Dates of Service**

Please list information below regarding paid work experiences that you have participated in:

Paid Work Experiences (two most current)					
Location	**Job Duties**	**Hours /Week**	**Supervisor**	**Phone #**	**Dates of Employment**
					Start and End of pay:
					Start and End of pay:

Support Services		
Are you eligible for services from OVR?	☐ **YES**	☐ **NO**
If YES, list the OVR Counselor's name: and phone number:		
Are you SSI or SSDI Eligible?	☐ **YES**	☐ **NO**
Have you been referred for services from County Developmental Services?	☐ **YES**	☐ **NO**
If yes, were you eligible for services from County Developmental Services?	☐ **YES**	☐ **NO**
If Yes, list the Developmental Services support coordinator's name: and phone number:		
If NO, are you interested in applying for eligibility?	☐ **YES**	☐ **NO**

Have you utilized services from other agencies in the past?	☐ YES	☐ NO

If yes, provide the details requested below: (counseling, Wrap Around, Intermediate Unit, etc.)

Past or present utilized Support Service Agencies:

Agency	Services Provided	Agency Contact	Phone #	Dates of Service

Living Arrangements and Daily Care

Who do you live with?

Do you get up in the morning on your own? If no, how do you wake up?	☐ YES	☐ NO

Performing daily care such as bathing, shaving, grooming, dressing, feminine hygiene, etc., do you complete these tasks with: (Please select one)	☐ Minimal Assistance	☐ No Assistance
	☐ Occasional Assistance	☐ Total Assistance

If assistance is needed, who assists you and to what degree?

What chores do you complete independently at home?

Medical History

Please list your medical, intellectual, developmental and/or mental health diagnosis:

_____

_____

_____

_____

_____

_____

Have you ever received any counseling or therapy?	☐ YES	☐ NO
If yes, please list the counselor and/or therapist's name: and phone number:		

 Client Name: _____

Please list any hospitalization and/or surgeries that you have had: (Additional sheet may be used if necessary)		
Date	**Hospital**	**Reason**

Do you have allergies? **If yes, what? (Medical, seasonal or food? Please describe severity)**	☐ **YES**	☐ **NO**
Please list any types of assistive technology, aids or support that you use:		

Please list all medications that you are currently taking: (Additional sheet may be used if necessary) ☐ **NONE**					
Medication	**Purpose**	**Dosage Amount**	**Dosage Schedule**	**Prescribing Physician**	**Physician Phone #**

Do you have an Emergency or Safety Plan? (Seizure plan, diabetes, allergies, etc.) **If yes, please attach plan or explanation.**	☐ **YES**	☐ **NO**
Do you wear glasses or contacts? **If yes, please explain the nature of your vision impairment:**	☐ **YES**	☐ **NO**
Do you use any devices or aids to assist with your hearing? **If yes, please explain the nature of your hearing impairment:**	☐ **YES**	☐ **NO**
Do you use sign language or any other nontraditional form of communication?	☐ **YES**	☐ **NO**
Do parents/guardians/family members use sign language, interpreter or any other nontraditional form of communication?	☐ **YES**	☐ **NO**

 Client Name: _____

Transportation Planning		
Do you currently hold a driver's license?	☐ YES	☐ NO
Do you currently hold a temporary driving license?	☐ YES	☐ NO
Do you have plans to take the temporary test?	☐ YES	☐ NO
Will you obtain a driver's license within the next year?	☐ YES	☐ NO
Will a family member provide you with transportation to the workplace after Project SEARCH? If yes, who?	☐ YES	☐ NO
Do you currently use public transportation without assistance?	☐ YES	☐ NO

Disability Awareness

Please use this space to list any health or medical issues that may impact a successful job placement. This should be completed by you or scribed using your own words. (An additional sheet may be used if necessary)

Please list the names and roles of the IEP team members and/or any others that assisted with the completion of this application:

Name	Position	Email	Phone Number

 Client Name: _____

I, _____, authorize all service providers , including but not limited to, educational institutions, County Developmental Services and Office of Vocational Rehabilitation to release all pertinent records and documentation to Lawrence County Project SEARCH. I further authorize these service providers to communicate with Lawrence County Project SEARCH about my records and services received. I understand that Lawrence County Project SEARCH will share and release all pertinent information, documentation, service records and medical records to the application screening committee members for the purpose of acceptance determinations and program planning.

_____	_____	_____
Print Your Name	**Your Signature**	**Date**
_____	_____	_____
Print Parent Name	**Parent Signature**	**Date**
_____	_____	_____
Print Legal Guardian Name	**Legal Guardian Signature**	**Date**

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

_____	_____	_____
Print Your Name	**Student Signature**	**Date**
_____	_____	_____
Print Parent Name	**Parent Signature**	**Date**
_____	_____	_____
Print Legal Guardian Name	**Legal Guardian Signature**	**Date**

Return completed Application by March 9, 2018 to:

Email: ProjectSEARCH@vpsdocs.com
Fax: **724.656.6870**
Mail: **Vocational & Psychological Services**
Attn: John Grimm
115 East North Street
New Castle, PA 16101

For questions, please call John Grimm at (724) 730-1422.