THE LEAGUE
FOR PEOPLE WITH DISABILITIES, Inc.
Putting Ability First

Criteria for Admission

Individuals referred to The League's Vocational Services Program must be eligible for funding through DDA, DORS, and Worker's Compensation, Private Pay or other funding source. Prior to acceptance into the program, Vocational Services must receive appropriate referral information documenting relevant disability information, needed services, funding available and any current services being received.

To be eligible for Vocational Services from The League, the individual must meet the following criteria:

- Individuals must be at least eighteen (18) years of age
- Individuals must be included, to the fullest extent of his/her ability in the application and selection process
- Individuals must desire employment as an outcome
- Individuals must have an available funding source
- Individuals must not be currently using or abusing illegal drugs and/or alcohol

All information contained in the attached application for services is confidential and is to be used only in the development of a vocational services plan. Information contained in this application may not be shared with others without written permission from the referred individual or the referred individual's representative.

If you have questions regarding the completion of this application, please contact Vanessa Foster at 410-323-0500 ext. 323. Upon completion, fax this form to:

ATTN: VANESSA FOSTER (410) 323-3298

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Application for Vocational Services

Personal Information

Full Name of Referred Individual :____
First Last MI

Date of Birth:_________________ Marital Status: ___________________________

Social Security Number:____________________ Race:_______________________

Address:____
Street City State Zip

Home Telephone:____________________ OtherTelephone:_____________________

Living Arrangements: Circle One

Independent With Parent/Family With Agency Provider

Residential Agency/Support (if applicable)

Name of Residential Agency/Support____

Contact Person:____________________________Telephone:____________________

____

Caseworker Information - Circle One:

Service Coordinator **DORS Counselor** **DSS Caseworker**

Name:___________________________________ Telephone:____________________

Office Address:____
Street City State Zip

Emergency Contact Information

Name:_________________________________ Relationship:__________________

Home Telephone:_______________________ Work Phone:_____________________

Cell Phone:____________________________ Other Phone:____________________

Legal Guardian (if not self):____

Guardian Telephone Number:

Home__________________ Work__________________ Cell___________________

Proof of Identification (circle all that apply)

Current Maryland State ID or Driver's License **Social Security Card**

If you don not possess both proofs of identification listed above, do you have any other forms of identification that the Motor Vehicles Administration will accept? If so, please list:____

Transportation

I use the following modes of transportation (circle all that apply)

MTA Bus **Paratransit Cab** **Family/Friends Transport**

Have own car/driver's license **Other**

Diagnosed Disability(ies):

____
____
____
____

Financial Information

Medical Assistance Number and MCO (if applicable:__________________________

Medicare Number:____

Other Insurance Name and Policy Number:

____

Name **Policy Number**

Benefits/Resources

Do you receive SSI?	**Yes**	**No**	**Amount per Month__________________**
Do you receive SSDI?	**Yes**	**No**	**Amount per Month__________________**
Do you receive assistance from DSS?	**Yes**	**No**	**Amount per Month__________________**
Do you have Medical Assistance?	**Yes**	**No**	**Amount per Month__________________**
Do you have Medicare?	**Yes**	**No**	**Amount per Month__________________**
Do you receive food stamps?	**Yes**	**No**	**Amount per Month___________________**

Do you handle your own benefits? **Yes** **No**

If no, who is your representative payee?

Name:______________________________ Telephone:_________________________

Average Monthly Expenses

List sources of expenses and approximate amount spent per month (example: rent, utilities, food, transportation, clothing)

1. Amount per Month:_____________

2. Amount per Month:_____________

3. Amount per Month:____________

4. Amount per Month_____________

Number of Dependents:____

Medical Information

Name of Primary Physician:____

Address:____
Street City State Zip

Telephone Number:____

Name of Mental Health Professional/Psychiatrist:______________________________

Address:____
Street City State Zip

Telephone Number:____

Allergies (please list all)____
____
____

Have you ever had a seizure? Yes No

If yes, list date of last seizure:____

Have you ever had a head injury? Yes No

If yes, describe how it occurred and when:
____
____

Are you currently on medication Yes No

If yes, please provide the following information:

Name of Medication	**Purpose**	**Dosage**	**Frequency Taken**

Do you have a history of substance abuse? Yes No
If yes, please explain:

____
____
____
____

Additional Personal Information

Have you ever been convicted of a felony? Yes No

If yes, please explain:

____
____
____
____
____
____
____
____

Do you require assistance with any of the following:

Using Bathroom	**Yes**	**No**
Walking	**Yes**	**No**
Mobility	**Yes**	**No**
Communication	**Yes**	**No**
Vision	**Yes**	**No**

Please provide as much information about your disability as you can to assist in the identification of supports needed to be successful in an employment situation:

____
____
____
____
____
____
____
____

Education

Name of High School____

Highest Grade Completed:________________ **Did you graduate?** **Yes** **No**

If "yes," did you graduate with a diploma or certificate?_______________________

If "no," do you have a GED? **Yes** **No**

Name of college, university or vocational school attended:_____________________

How many years attended?____________ **Degree or Certificate?**_______________

Employment/Volunteer History

Please complete the following section listing your MOST CURRENT paid or volunteer job first

Position Title:____

Company Name and Address:____
Name

____
Street **City** **State** **Zip**

Supervisor Name:________________________ **Phone:**_____________________

From ________________ **to** _______________ **Ending salary:**________________

Primary Responsibilities:

____
____
____
____

Position Title:____

Company Name and Address:____
Name

____
Street **City** **State** **Zip**

Supervisor Name:________________________ **Phone:**_____________________

From ________________ **to** _______________ **Ending salary:**________________

Primary Responsibilities:

____
____
____
____

Position Title:____

Company Name and Address:____
Name

____
Street **City** **State** **Zip**

Supervisor Name:__________________________ **Phone:**_______________________

From _________________ **to** ________________ **Ending salary:**_________________

Primary Responsibilities:

____
____
____
____

Position Title:____

Company Name and Address:____
Name

____
Street **City** **State** **Zip**

Supervisor Name:__________________________ **Phone:**_______________________

From _________________ **to** ________________ **Ending salary:**_________________

Primary Responsibilities:

____
____
____
____