WORK, Inc.
25 Beach Street
Dorchester MA 02122-2734
Phone: 617.691.1702
Email: info@Pathwaystocareers.org

NOTE: THIS APPLICATION MUST BE SUBMITTED BY END OF BUSINESS TUES. MAY 10, 2016

Application

Please feel free to ask for an accommodation or assistance if necessary to complete this application. If you need assistance, please contact: **617.691.1707**

OFFICE USE ONLY
☐ Completed Application
☐ Consent Form
☐ Reviewed by CN on Date_____

Referring Organization:
☐ MA DDS ☐ MRC ☐ WORK Inc. ☐ Other:_____

SECTION 1. APPLICANT INFORMATION

Last Name:	First:	M.I.:	Date:
Street Address:		Apartment/Unit #:	
City:	State:	ZIP: Date of Birth:	____/____/____ Mo / DD / YYYY
County:	Home Phone:	Cell Phone:	
Email address:		Social Security #: _____ - _____ - _____	
Sex: ☐ Female ☐ Male	Marital Status: ☐ Single (never married) ☐ Married ☐ Divorced/separated/widowed		

Do you have any children? ☐ Yes ☐ No If yes, do any of these children live with you? ☐ Yes ☐ No
If any of these children live with you, are any of these children under age 6? ☐ Yes ☐ No

Do you have a legal guardian? ☐ Yes ☐ No If yes, please list their name and contact number

_____

Do you have a representative payee? ☐ Yes ☐ No If yes, please list their name and contact number

_____

Do you currently receive MRC or DDS supports? ☐ Yes ☐ No
If yes, please list your counselor/Service Coordinator's name and contact number_____

_____

Race (check all that apply): ☐ American Indian ☐ Asian ☐ Black ☐ White
☐ Other (specify)_____

Hispanic or Latino ethnicity: ☐Yes ☐ No

Primary Language spoken at home: ☐ English ☐ Spanish ☐ Other Specify _____

Section 2. PERSON FILLING OUT THIS FORM (if different from the Applicant)

Last Name:	First Name:		
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	

Type of Relationship to Applicant: (check all that apply):

☐ Natural Parent ☐ Guardian ☐ Relative ☐ Non-relative ☐ Group home or service provider

☐ Representative Payee ☐ Other: _____

Section 3. ALTERNATE CONTACT

Last Name:	First Name:		
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	

Type of Relationship to Applicant (check all that apply): ☐ Natural Parent ☐ Guardian ☐ Relative
☐ Non-relative ☐ Other_____

SECTION 4. LIVING ARRANGEMENT

Which of the following best describes you (the applicant's) current living arrangement?

☐ Live alone
☐ Live with parents or guardian
☐ Live with spouse or partner
☐ Live with other relatives
☐ Live with roommates/unrelated others
☐ Live in a group with others with disabilities
☐ Other (specify)_____

SECTION 5. ELIGIBILITY CRITERIA

Do you currently participate in a Community Based Day Program? YES ☐ NO ☐

Are you interested in working a minimum of 20 hours per week or more? YES ☐ NO ☐

Are you currently participating in an Employment program and preparing to work? YES ☐ NO ☐

If YES, please specify:

Are you currently receiving SSI/SSDI Benefits? YES ☐ NO ☐

If you are not currently receiving Social Security disability benefits, will you likely receive SSI in the next year?
YES ☐ NO ☐ UNCERTAIN ☐

Income and Program Participation

What was your (the applicant's) total family income last year before taxes? Please include income received by all members of the family. Include any cash benefits your family may have received.

□ Less than $10,000
□ $10,000-$24,999
□ $25,000 or more

Tell us about the programs you have participated in below

Program	Ever in program	In program last month	Program benefit last month
Supplemental Security Income (SSI)	YES ☐ NO ☐	YES ☐ NO ☐	$_____ per month
Social Sec. Disability Insurance (SSDI)	YES ☐ NO ☐	YES ☐ NO ☐	$_____ per month
Food Stamps (SNAP)	YES ☐ NO ☐	YES ☐ NO ☐	$_____ per month
State Vocational rehabilitation services	YES ☐ NO ☐	YES ☐ NO ☐	[redacted]
Medicare	YES ☐ NO ☐	YES ☐ NO ☐	
Medicaid	YES ☐ NO ☐	YES ☐ NO ☐	

SECTION 6. DISABILITY INFORMATION

What is your (the applicant's) primary disability? Please mark the number from the list below _____. At what age did this disability begin? _____

Do you (the applicant) have other disabilities? If yes, please specify up to three from the list below:

(number from list)_____, which began at age_____
(number from list)_____, which began at age_____
(number from list)_____, which began at age_____

1. Autism
2. Blindness/visual impairment
3. Cerebral palsy
4. Cystic fibrosis
5. Deafness/hearing impairment
6. Emotional disorder/including chronic mental illness
7. Epilepsy/convulsive disorder
8. Head/brain injury
9. Learning disability (specify)_____
10. Developmental disability
11. Multiple sclerosis
12. Muscular dystrophy
13. Speech/language disability
14. Spina bifida
15. Spinal cord injury
16. Other genetic disorder (specify)_____
17. Other neurological disorder (specify)_____
18. Other physical impairment (specify)_____

Please indicate if you (the applicant) have difficulty with any of the following activities, and if so, if you require special equipment or help from another person to do the activity?

Do you (the applicant) experience difficulty……		Do you require special equipment or help from another person to do the activity?
Walking, standing, or climbing the stairs?	☐ YES ☐ NO	☐ YES ☐ NO
Dressing, bathing, eating, or getting around inside the home?	☐ YES ☐ NO	☐ YES ☐ NO

Getting around outside of the home, or accessing transportation?	☐ YES ☐ NO	☐ YES ☐ NO
Doing errands on your own, like shopping and doctor visits?	☐ YES ☐ NO	☐ YES ☐ NO
Speaking, communicating with others?	☐ YES ☐ NO	☐ YES ☐ NO
Hearing normal conversations?	☐ YES ☐ NO	☐ YES ☐ NO
Seeing, even with the use of prescription glasses?	☐ YES ☐ NO	☐ YES ☐ NO
Planning and carrying out activities to achieve a goal?	☐ YES ☐ NO	☐ YES ☐ NO
Learning, remembering, or concentrating?	☐ YES ☐ NO	☐ YES ☐ NO
Getting along with others in social, work or school settings?	☐ YES ☐ NO	☐ YES ☐ NO

In general how would you describe your (the applicant's) health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

SECTION 7. EDUCATION

What is the highest level of education you (the applicant) have completed?

☐ 8Th grade or less
☐ Some high school (9th – 12th) and no high school diploma
☐ High school diploma, completion certificate, or GED
☐ Some college or some of a post-secondary technical or vocational program (did not receive a degree/cert.)
☐ Other (specify)_____

Do you (the applicant) currently attend school? YES ☐ NO ☐

If yes, which of the following best describes your (the applicant's) school:

☐ A general high school for students with or without disabilities
☐ A special high school for students with disabilities
☐ An ungraded school
☐ A college or other post-secondary program
☐ Other (specify)_____

SECTION 8. EMPLOYMENT GOALS/HISTORY

Have you participated in a volunteer work experience?	YES ☐ NO ☐ If yes, for how many months was the most recent experience? _____	If yes, did you receive ongoing employment support? YES ☐ NO ☐
Have you participated in a paid work experience arranged by school or a program?	YES ☐ NO ☐ If yes, for how many months was the most recent experience? _____	If yes, did you receive ongoing employment support? YES ☐ NO ☐
Have you ever been enrolled or employed at a community rehabilitation program?	YES ☐ NO ☐ If yes, for how many months was the most recent experience? _____	

Do you see yourself working in the near future? YES ☐ NO ☐ Uncertain ☐

If yes, how much time would you want to work?
Part time ☐ Full time ☐ Other ☐ Specify _____

If living with parents/guardians: Do your (the applicant's) parents/guardians expect you to work in the future?
YES ☐ NO ☐ Uncertain ☐

If in school, do your (the applicant's) teachers or counselors expect you (the applicant) to work in the future?
YES ☐ NO ☐ Uncertain ☐

Have you (the applicant) ever held a job for pay? YES ☐ NO ☐
If Yes, are you (the applicant) currently employed for pay? YES ☐ NO ☐

If not currently employed for pay, then when were you (the applicant) last employed for pay?
_____/_____ (MM/YYYY)

If employed during the last six months, please tell us about your (the applicant's) current or most recent job:

When did you start this job? _____/_____
MM YYYY

When did this job end? _____/_____
MM YYYY

In a typical week, how many hours did you work at this job? _____

How much do/did you earn at this job before taxes? $_____ per _____

Does/did this job offer health insurance? YES ☐ NO ☐ Uncertain ☐
If YES, are/were you enrolled in the plan? YES ☐ NO ☐

Are/were most of your co-workers people with disabilities? YES ☐ NO ☐ Uncertain ☐

If you (the applicant) are selected, to participate this year, please indicate your first, second and third preference for when you can start:

_____Spring, 2016 _____Mid-Summer, 2016 _____Late Fall, 2016

SECTION 9. TRANSPORTATION

Check all primary modes of transportation:

☐ **Own Vehicle** ☐ **MBTA trains and busses** ☐ **The Ride** ☐ **Relative** ☐ **Friend** ☐ **Walk** ☐ **Bike**
☐ **Other** _____

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

I understand that false or misleading information in my application or interview may result in my release from the program.

Applicant's Signature:	Date:
Parent/Guardian's Signature:	Date: