**INDIVIDUAL ELIGIBILITY EVALUATION**

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 Type of review: Initial \_\_\_\_ Annual \_\_\_ (indicate with an "x")

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Name: \_\_\_\_\_\_\_\_\_\_\_\_ Employee Number: \_\_\_\_\_\_\_\_\_\_

**I. Background Information**

Date of Hire: \_\_/\_\_/\_\_\_\_ Current Job Title: \_\_\_\_\_\_\_\_\_\_\_

 Current Job Location/Project: \_\_\_\_\_\_\_\_\_\_\_\_

Information considered pertinent to or supporting the evaluation: (please explain below)

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

**II. For people who are blind**

Medical Documentation: (please check one of two)

Signed eye exam with person’s visual acuity or field of vision specified \_\_\_\_\_

Signed letter from Government Agency stating that individual is blind \_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_

Certifier’s Name: \_\_\_\_\_\_\_\_\_\_

Date of Document: \_\_/\_\_/\_\_\_\_

**Competitive employability**

Is this individual currently capable of competitive employment? \_\_\_Yes \_\_\_No (mark with an "x")

If yes, does he or she desire to be placed in competitive employment? \_\_\_Yes \_\_\_No (mark with an "x")

If the individual wishes placement in a job in the community what steps are being taken to place the individual: (please explain below)

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

**III. For people who are severely disabled**

Medical Documentation: (check one of two

 Documentation is signed by physician, psychiatrist, or psychologist \_\_\_\_\_

 Signed letter from Government Agency stating the individual’s diagnoses \_\_\_\_\_

Synopsis of severe disabilities (This individual has the following disabilities)

Disability1: \_\_\_\_\_\_\_\_\_

Doctor’s Name1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certifier’s Name1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Document1: \_\_/\_\_/\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_

Doctor’s Name2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certifier’s Name2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Document2: \_\_/\_\_/\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_

Doctor’s Name3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certifier’s Name3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Document3: \_\_/\_\_/\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_

Doctor’s Name4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certifier’s Name4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Document4: \_\_/\_\_/\_\_\_\_

Synopsis of functional limitations (This individual has the following limitations in self-care, self-direction, work skills, work tolerance, communication and or mobility as a direct result of the documented impairment)

Disabilities (list individual disabilities):

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

Impaired Major Life Function (mark specific affected life functions with an “x” for each disability below)

**Communication**

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

**Mobility**

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

**Self-Care**

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

**Self-Direction**

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

**Work Tolerance**

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

**Work Skills**

Disability1: \_\_\_\_\_\_\_\_\_\_

Disability2: \_\_\_\_\_\_\_\_\_\_\_

Disability3: \_\_\_\_\_\_\_\_\_\_\_

Disability4: \_\_\_\_\_\_\_\_\_\_

Competitive employability

Is this individual currently capable of competitive employment (obtaining and maintaining a job without supports from the nonprofit agency)?

 \_\_\_YES \_\_\_NO (mark with an "x")

If the answer above is no, detail the individual’s functional limitations below and what accommodations or supports not normally provided in typical community employment are being provided:

Functional Limitation: Again, after each one, give details for the Functional Limitations and details for the Supports and Accommodations:

**Mobility**

Functional Limitation: \_\_\_\_\_\_\_\_\_\_\_

Support Being Provided: \_\_\_\_\_\_\_\_\_\_\_\_

**Communications**

Functional Limitation: \_\_\_\_\_\_\_\_\_\_\_

Support Being Provided: \_\_\_\_\_\_\_\_\_\_\_\_

**Self-Care**

Functional Limitation: \_\_\_\_\_\_\_\_\_\_\_

Support Being Provided: \_\_\_\_\_\_\_\_\_\_\_\_

**Self-Direction**

Functional Limitation: \_\_\_\_\_\_\_\_\_\_\_

Support Being Provided: \_\_\_\_\_\_\_\_\_\_\_\_

**Work Tolerance**

Functional Limitation: \_\_\_\_\_\_\_\_\_\_\_

Support Being Provided: \_\_\_\_\_\_\_\_\_\_\_\_

**Work Skills**

Functional Limitation: \_\_\_\_\_\_\_\_\_\_\_

Support Being Provided: \_\_\_\_\_\_\_\_\_\_\_\_

**IV. Evaluator: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_

Location/Program: \_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_

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