OPWDD Supported Employment Services
Application

Applicant's Name: ________________________ Date: ________________________

Address: ____

Telephone #: ______________________ Date of Birth: ______________________

Medicaid #: _______________________ Current Services: ___________________
(i.e. Day Hab, Res Hab, Comm Hab, Other Vocational, etc.)

Applying for: ❑ SEMP Intensive ❑ SEMP Extended

Referral from ACCES-VR: ❑ Yes ❑ No Date of ACCES-VR closure: __________

Waiver Enrolled: ❑ Yes ❑ No* * Limited Exception

Self-Directed: ❑ Yes* ❑ No * If yes, provide copy of Self-Directed Budget

Self-Employed: ❑ Yes ❑ No

Family Contact

Name: ______________________________

Address: ____________________________

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Phone: ______________________________

Residential Provider Contact

Name: ______________________________

Address: ____________________________

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Phone: ______________________________

Care Manager Contact

Name: ______________________________ Phone: ____________________________

CCO Agency: ________________________ Email: ____________________________

Please answer the following questions:

- Please list your volunteer and/or work history (if currently employed, include present job details):
  ____
  ____

What type of work are you interested in?

❑ Food Service ❑ Janitorial
❑ Customer Service ❑ Clerical
❑ Other __________

Mobility:

❑ Independent ❑ Physical Assistance
❑ Walker ❑ Wheelchair

Work Accommodations:

❑ Independent ❑ Assistance needed with reading
❑ Cannot lift more than 25 lbs. ❑ Assistance needed with writing
❑ Cannot stand for more than 15 minutes ❑ Adaptive equipment needed
❑ Other __________

Dining Needs:

❑ Independent ❑ Food needs to be prepared (cut up/ground)
❑ Choking Risk ❑ Food Allergies ______________________
❑ Other __________

Supervision in the Community:

❑ Independent ❑ Amount of time can be left alone __________
❑ General Monitoring ❑ Frequency that visual checks need to occur _________

Transportation:

❑ Drives independently ❑ Uses public transport (i.e. Centro Bus, taxi service, etc.)
❑ Relies on support ❑ Other __________
*** ❑ Check box if interested in travel training ***

Behavior Concerns:	**Occasionally**	**Monthly**	**Weekly**	**Daily**
Socially Inappropriate				
Emotional Outbursts				
Verbally Abusive				
Harasses Others				
Elopement				
Steals				

➢ Additional information regarding the above or any other medical or physical restrictions, barriers to employment, needs, or concerns:

➢ **Please Attach:**

- A copy of the applicant's most current Life Plan
- Current LCED
- Initial LCED (with physician signature)
- Waiver Notice of Decision (NOD – all pages)
- Current Psychological Evaluation
- Letter of Eligibility Determination
- OPWDD Approval Letter to receive SEMP services (RSA/SARF)
- Copy of Medicaid Card
- Identification documents (for I-9 Employer identification verification): Copy of Social Security Card, Birth Certificate, Permit/License/Non-Drivers ID as applicable
- If currently employed: Copy of recent Pay Stub (for verification of minimum wage requirement)
- Any vocational assessments previously administered
- Resume if applicable
- Self-Directed Budget if applicable

Completed By: ______________________________

Date: ___________________

For any questions and/or to submit completed application, please contact:

Kelsey Gibb, Employment Options Manager
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