



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: _____

Phone: _____

Residential Provider Contact

Name: _____

Address: _____

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
- Customer Service
- Other _____
- Janitorial
- Clerical

Mobility:

- Independent
- Walker
- Physical Assistance
- Wheelchair

Work Accommodations:

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

Dining Needs:

- Independent
- Choking Risk
- Other _____
- Food needs to be prepared (cut up/ground)
- Food Allergies _____

Supervision in the Community:

- Independent
- General Monitoring
- Amount of time can be left alone _____
- Frequency that visual checks need to occur _____

Transportation:

- Drives independently
- Relies on support
- Uses public transport (i.e. Centro Bus, taxi service, etc.)
- Other _____

*** Check box if interested in travel training ***

Behavior Concerns:
Socially Inappropriate

Occasionally Monthly Weekly Daily

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:

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Phone: 315-884-0327