

**INDIVIDUAL ELIGIBILITY EVALUATION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Type of review:* ***Initial*** ***[ ]  Annual*** ***[ ]***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: Click here to enter text. Employee Number: Click here to enter text.

**I. Background Information**

Date of Hire: Click here to enter text. Current Job Title: Click here to enter text.

 Current Job Location/Project: Click here to enter text.

Information considered pertinent to or supporting the evaluation:

Click here to enter text.

**II. For people who are blind**

Medical Documentation

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 [ ]

If yes, does he or she desire to be placed in competitive employment? Yes [ ]  No [ ]

If the individual wishes placement in a job in the community what steps are being taken to place the individual: Click here to enter text.

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

Medical Documentation

 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)

|  |  |  |  |
| --- | --- | --- | --- |
| Disability | Doctor’s Name | Certifier’s Name | Date of Document |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

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) |
| Impaired Major Life Function | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Communication | [ ]  | [ ]  | [ ]  | [ ]  |
| Mobility | [ ]  | [ ]  | [ ]  | [ ]  |
| Self-Care | [ ]  | [ ]  | [ ]  | [ ]  |
| Self-Direction | [ ]  | [ ]  | [ ]  | [ ]  |
| Work Tolerance | [ ]  | [ ]  | [ ]  | [ ]  |
| Work Skills | [ ]  | [ ]  | [ ]  | [ ]  |

Competitive employability

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

 YES [ ]  NO [ ]

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

|  |  |  |
| --- | --- | --- |
| **Functional Limitation** | **Functional Limitation Details** | **Supports and Accommodations** |
| Mobility |       |       |
| Communications |       |       |
| Self-Care |       |       |
| Self-Direction |       |       |
| Work Tolerance |       |       |
| Work Skills |       |       |

**IV. Evaluator** Date: Click here to enter a date.

Name: Click here to enter text.

Title: Click here to enter text.

Location/Program: Click here to enter text.

Signature: