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: _____