

**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. |
| Mobility |  |  |  |  |
| Communication |  |  |  |  |
| 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: