



INDIVIDUAL ELIGIBILITY EVALUATION



Disability Qualification Determination

Directions: Complete this form to determine eligibility as a qualified direct labor employee whose work will be counted as hours performed by a blind or significantly disabled individual as required by U.S. AbilityOne Commission Compliance Policy 51.403.

Type of Disability review: ~~Initial~~ Annual

Permanent Disability(ies) (One-time submission)

Non-Permanent Disability(ies) (7-year review)

*Permanent Disability is defined as: A significant physical or mental disability that is not expected to substantially improve during an individual's lifetime.

Form Reference Number: [The form reference number is randomly generated by the NPA and is submitted into the CNA's electronic data base with the information on this form. The employee's name associated with the form reference number and any medical documentation concerning the employee are maintained solely by the NPA. The CNA will receive such identifiable information regarding the employee during an oversight visit if this form is reviewed by the CNA.]

Name: [Click here to enter text.](#) Employee Number: [Click here to enter text.](#)

I. Background Information

Date of Employee's Hire: [Click here to enter text.](#)

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Date of Employee's Eligibility Determination (if different from date of hire): Current Job Title: [Click here to enter text.](#)

Nonprofit Agency (NPA) Name: Current Job Location/Project: [Click here to enter text.](#)

Information considered pertinent to or supporting the evaluation:

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Section A. For people who are blind

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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

The individual is blind as defined in 41 CFR 51-1.3. **Blind** means an individual or class of individuals whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity, if better than 20/200, is accompanied by a limit to the field of vision in the better eye to such a degree that its widest diameter subtends an angle no greater than 20 degrees.)

Yes - Complete the Section A information below, then proceed to Section G.

Doctor's Name	Certifier's Name	Date of Document
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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.](#)

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III. For people who are severely disabled

Medical No (Proceed to Section B)

Section B. Individuals with Government Documentation Establishing Full Eligibility

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The 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) is receiving or is eligible for:

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SSI (based on disability)

SSDI

Medicaid (based on disability)

Disability	Doctor's Name	Certifier's Name	Date of Document

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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)

Note: This government documentation does not need to identify the individual's specific disability. The individual's disability will be identified in the annual Participating Employee Information Form. The documentation also does not need to be signed by a government official.

If any of the above three certifications are selected, proceed to Section G.

The individual is not receiving or eligible for any of the benefits listed above (Proceed to Section C).

Section C. Individuals with Other Government Documentation

The individual is receiving or is eligible for:

Vocational Rehabilitation Services

- Veterans' benefits based on disability/ Veteran Readiness & Employment Services
- State Developmental Disability Services
- Other Federal, State, or Local Disability Certification
- School-to-Work transition services from educational systems for individuals over the age of 18.
- IEP, due to a permanent or temporary disability(ies), within 5 years of graduation/exit from school.

Date of Document	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Direction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above are selected, proceed to Section E.

~~The Competitive employability~~

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

_____ YES _____ NO

is not receiving any of 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: (Proceed to Section D)

Section D. Individuals with Medical Documentation

The individual has been diagnosed by a qualified licensed professional to have a disability.

Yes (Proceed to Section E.)

No

Functional Limitation	Qualified Licensed Professional's Name	Functional Limitation Details	Date of Document

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Mobility	_____	_____
Communications	_____	_____
Self-Care	_____	_____
Self-Direction	_____	_____
Work-Tolerance	_____	_____
Work-Skills	_____	_____

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If "No" is selected above, and documentation was not provided in sections A, B, or C, the individual is not eligible to be counted in the ODLH ratio as blind or significantly disabled.

Section E. Significant Job Supports – complete for individuals whose documentation is covered in Sections C or D above.

Significant job support(s) are defined in Commission Policy 51.403 as: One or more accommodation(s) or adaptation(s) needed by an individual with a physical or mental disability and that may be extensive and ongoing in order for that individual to be successful in the job position.

Which significant job support(s) does this individual need to overcome barriers to competitive employment, as a result of the individual's disability(ies)?

- Access/Assistive Technology: Devices or software to aid communication
(e.g., screen readers, voice recognition software, screen magnifiers)
- Adaptive Equipment: specialized tools or equipment to assist with tasks associated with daily living
- Additional and/or enhanced training to meet essential job functions
- ASL Interpreter
- Emotion regulation and coping skill support
(e.g., for individuals with mood disorders or autism)
- Enhanced supervisory support and/or modified duties
(e.g., for people with intellectual/developmental disabilities)
- Job Coaching
- Medical accommodations: reduced/modified schedule to provide extra breaks or significant time for medical administration
- Modified essential job functions
- Personal Care Attendants or Aides
- Ramps, automatic door openers, or other significant physical modifications
(e.g., for people using mobility devices or individuals with musculoskeletal disabilities)
- Reader/Scribe
- Reduced qualitative or quantitative performance standards

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Narrative: How often are the above job support(s) needed and why are they necessary?

IV. Evaluator

Date: [Click here to enter a](#)

[date:](#)

Name: [Click here to enter text.](#)

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Other Significant Job Supports

If other significant job supports are provided, in sufficient detail describe the job support (s) provided, why the job support(s) are necessary and why they are extensive and/or ongoing. [Click here to enter text.](#)

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Title: [Click here to enter text.](#)

Section F. Attestation

The evaluator has read U.S. AbilityOne Commission Policy 51.403, has reviewed the supporting documentation of eligibility required by this form, and has confirmed that the direct labor employee meets the eligibility standards for an individual who is blind or has a significant disability as set forth in Policy 51.403.

Section G. Evaluator

Date of Determination: [Click here to enter a date.](#)

Location/Program: [Click here to enter text.](#)

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Name: [Click here to enter text.](#) Title: [Click here to enter text.](#)

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Signature: _____

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TO BE COMPLETED BY CNA/U.S. ABILITYONE COMMISSION – COMPLIANCE INSPECTION

Date: [Click here to enter a date.](#) CNA/Commission: [Click here to enter text.](#)

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Signature: _____

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