

 



Florida Adult Project SEARCH

Application

2022

APPLICATION FOR PARTICIPATION Please return to jwilliams@arcputnam.org



 Participant Information

| Name  |  |   |   |   |   |
| --- | --- | --- | --- | --- | --- |
|  Last    Address:  | First     |  | Middle   | Nickname (if applicable)      |
|  Street    | City  |  |  | Zip Code    |
| Date of Birth:  |  |  |  Male  |  |  Female  |   |
|  Primary Caretaker /Guardian Name:  | Primary Caretaker /Guardian e-mail:  |  |   |  Do you have a court appointed guardian?  |

☐Yes

☐No

 Address:

|  Street  | City  | Zip Code  |
| --- | --- | --- |
|  Primary Caretaker/Guardian Home Phone:  |  Cell Phone:  |    |
|  Work Phone:  |   |   |

 Primary Caretaker/Participant Release of Information:

Release: I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Participant / Guardian, if applicable) agree to have my records from service agencies (E.G. APD)

released to the following as needed: ☐ Arc of Putnam ☐ Vocational Rehabilitation

 ☐ Project SEARCH ☐Beck Automotive Group

The following records may be released:

☐Support Plan ☐IPE

☐Progress Notes/Summaries ☐Other important documents not listed:

 Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  Participant  |  |  |
| --- | --- | --- |
| Signature:  |   | Date:  |



COMMUNITY WORK/EMPLOYMENT/VOLUNTEER INFORMATION:

List work experiences/ jobs done in the community, disability agency or home:

| Employer/Organization/ Home  | Job Title/ Job/ chores  | Dates  | Contact Number  |
| --- | --- | --- | --- |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

After the Project SEARCH program is completed, do you plan on getting and maintaining a

 Full time job  Or a Part time job 

TRANSPORTATION:

How do you plan to get to Project SEARCH?

 Public   Bike  Other (please 

Transit, if Parents/Guardian, specify) List: available caretaker

SERVICE AGENCIES:

Do you have a Vocational Rehabilitation Counselor?

Yes  No  Counselor’s Name: Contact Number:

Are you currently receiving services and/ or employment services from any other agencies? (example Agency for Persons with Disabilities)

☐YES☐ NO Please list: Contact Person name:

 Contact Person Email:

INDEPENDENT LIVING:

Medications/Dosage/Time of day taken by participant

| Medication  | Dosage  | Time of day  |
| --- | --- | --- |
|   |   |   |
|   |   |   |
|   |   |   |

List any health or medical issues that may impact a successful job placement:







Please list any limitations that may impact an internship rotation or employment:





Please describe any special accommodations you may need based on the above:





BEHAVIORAL HEALTH SUMMARY:

Do you have any behavioral health issues which might impact a successful job placement? If yes, please describe any related accommodations needed to be successful.

 Yes  No 

Please Explain:







PARTICIPANT RESPONSE QUESTION

Why do you want to come to Project SEARCH? (Participant’s words/response)















This application has been completed by:



 Name Title Phone Number Date



Signature