i-Ability: Vocational IT Training Program Application Form

Dear Applicant,

Thank you for your interest in the **i-Ability: Vocational IT Training Program**, which is offered by Hire-Ability Vocational Services, a division of Richmond Area Multi-Services, Inc. (RAMS) with funding from the Mental Health Services Act. We are excited to announce that we are currently seeking applicants for the upcoming cohorts for two tracks: (1) Help Desk and (2) Desktop.

Participants in these 9-month program tracks will receive intensive and supportive on-the-job training in the fields of information technology, technical support and customer service. Please visit www.hire-ability.org, where you can access videos that provide information about how to prepare yourself for the application process and the program itself.

In order to qualify for this program, please note that **you must be able to provide documentation showing that you meet the following requirements**:

1. At least 18 years of age
2. Current resident of San Francisco
3. Must be **currently** receiving services through SFDPH Behavioral Health Services (BHS)
4. Have successfully completed at least a High School education or equivalent (GED acceptable)
5. Be able to attend training which is held Monday to Friday, between 8:30am and 5pm, 7-12 hours per week
6. Successful completion of in-person interview and skills assessment
7. Must actively participate in developing vocational goals with program staff
8. Must provide consent for i-Ability staff to reach out to clinical provider

The program is accepting about 7-10 trainees for the Help Desk track and 6-8 trainees for the Desktop track. Interviews will be conducted on an ongoing basis. For example, if an application is submitted on January 1, we will do our best to conduct the interview by January 31 or sooner. A checklist has been provided in this application to ensure that all required documents have been submitted.

Please visit **www.hire-ability.org** for more information about the specific deadlines for each cohort or training period.

The program respects your privacy and adheres to the confidentiality rules and regulations that apply. The information on your application will not be shared with anyone without your prior consent. Should you have any questions, please feel free to contact me directly. Thank you again for your interest in the i-Ability Vocational IT Training Program.

Sincerely,
John Cabiles
Vocational IT Services Manager
(415) 282-9675 ext. 231
iAbility@hire-ability.org

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I. Applicant Information *Please complete all fields below*			
First Name:		Last Name:	
Phone:		Email:	
Address:			

II. Training Track Preference *Please check only one box*	
Which program track do you most prefer?	☐ Desktop ☐ Help Desk

III. Program Requirements

*Note: You must answer **Yes** to all of the following questions in order to be eligible for this program*

1. Are you currently a San Francisco resident? ☐ Yes ☐ No
2. Are you a High School graduate or equivalent (GED)? ☐ Yes ☐ No
3. Are you currently receiving services through BHS?* ☐ Yes ☐ No ☐ Not Sure
4. Are you able and willing to commit to the full nine month training program? ☐ Yes ☐ No
5. Can you commit to 7-12 hours per week? (Mon-Fri, between 8:30am and 5pm) ☐ Yes ☐ No

* **If you are not currently working with BHS, please call (415) 503-4730 for linkage to services**

IV. Training & Work Experience *Please list past training, volunteer or work experience **OR** attach your resume*			
Description/Job Title/Training Course	Organization/Employer/School	Start Date	End Date

V. References *Note: A clinical reference is **required***			
Reference Type	Name	Phone Number	Email (required for clinician)
Clinical (e.g., therapist, psychiatrist, case manager)			
Professional (e.g., employer, teacher, volunteer coordinator)			

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VI. Personal Statement

Use the space below **OR** attach your personal statement

In no more than 2 pages, please complete a personal statement answering all of the following questions. Please note that both *typed* and *handwritten* statements are acceptable.

You may attach your statement in lieu of using the spaces below.

1. **Will you meet the basic requirements and expectations of the program? If so, explain.**
2. **Why are you interested in joining this program?**
3. **It is a program expectation that trainees will work on their weaknesses and respond positively to constructive feedback. How will you meet this expectation?**
4. **It takes a lot of commitment to complete this program. What challenges do you anticipate for yourself, and how do you hope to manage those issues? (You must describe at least one challenge).**

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VI. Personal Statement
Continued

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Completed Application Checklist

Please do not submit your application until you have completed all of the tasks below.

Note to reapplicants: you are still required to submit all of these documents even if you think that the program staff already has a copy of them.

☐ Fill out entire application form

☐ Attach copy of proof of San Francisco residency (driver's license or CA state ID)

☐ Attach copy of proof of eligibility to work (social security card, US passport, residency card)

☐ Attach your personal statement

☐ Attach **Vocational Referral (Access4Jobs)** form *(must first be completed and signed by your clinician)*

☐ Attach signed Authorization for Use or Disclosure of Protected Health Information form *(please complete this authorization form, sign it, and give it to your clinician)*

Note: For your security, we recommend that you password-protect any documents before emailing them.

Signature

Please read each paragraph, and then sign below.

I permit RAMS to contact the references I provided regarding the i-Ability training program. I authorize the references I have listed to provide any information about my related experiences, without giving me prior notice of such disclosure.

I certify that I have not purposely withheld any information that might negatively affect my chances for acceptance. The answers given by me are true and correct to the best of my knowledge and ability.

Applicant's Signature: _____ Date: _____

You must submit your *completed* application no later than the 5:00PM deadline listed at www.hire-ability.org

Applications may be dropped off OR mailed to:	Alternatively, applications may be emailed or faxed:
Attn: Vocational IT Manager Hire-Ability 1234 Indiana Street San Francisco, CA 94107	Email: iability@hire-ability.org Fax: (415) 920-6877 *Note: If you are faxing your application, please call to ensure that it has been received.*

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Demographic Information Questionnaire (optional)

This information is for data collection purposes only. By completing this form, you will help us to improve our outreach efforts to underserved populations. The i-Ability Program respects your privacy and we are bound by the confidentiality rules and regulations that apply.

1. **Date when you submitted your application:** _____

2. **Gender (check one):** ☐ Female ☐ Male ☐ Trans Female
   ☐ Trans Male ☐ Intersex ☐ Gender Non-Conforming
   ☐ Other _____

3. **Age Group in years (check one):** ☐ 0-18 ☐ 16-24 ☐ 25-59 ☐ over 60

4. **Ethnicity (check all that apply):** ☐ African-American ☐ Asian ☐ Pacific Islander
   ☐ Native American ☐ Latino ☐ White
   ☐ Other _____

5. **Primary Language:** _____

6. **Secondary Languages (if any):** _____

7. **Highest Level of Education (check one):** ☐ High School/GED ☐ Some College
   ☐ College Graduate ☐ Graduate School

8. **Which clinic employs your mental health provider:** _____

9. **How often do you see your clinician:** ☐ Every Week ☐ Every 2 Weeks
   ☐ Every Month ☐ Never
   ☐ Other _____

10. **Which benefits are you currently receiving:** ☐ SSI ☐ SSDI ☐ None

11. **How did you learn about this program:** ☐ Clinician ☐ Information Session
    ☐ Brochure/Flyer ☐ i-Ability Program Graduate
    ☐ Other _____

Vocational Referral

Access4Jobs

The San Francisco Vocational CO-OP

Serving SF residents with primary mental health diagnosis(es)

Thank you for your interest in Vocational and Employment Services

Client Name _____ DOB _____

Primary/Language _____ Ethnicity _____ Gender _____

Address _____ Zip Code _____ Phone _____

Email _____ How did you hear about us ☐ Clinician ☐ Outreach/Poster ☐ Friend ☐ Other

Case Mgr. /Therapist _____ Email _____

Agency _____ Contact # _____

What is your Vocational Goal? ☐ Paid Employment ☐ Training/Education

Vocational Interest _____

What is your program of interest? *(If no preferred service, referral will be based on appropriate match)*

☐ **RAMS Hire-Ability** ☐ **Citywide** ☐ **Caminar** ☐ **OTTP-SF** ☐ **Toolworks** ☐ **PRC**

See other side for an explanation of each program

Can you provide documentation to work in US? ☐ *Your response is confidential. If you do not have documentation, Access4Jobs may still be able to refer you to vocational services.*

I authorize my diagnosis(es)/clinical information to be released by the referring source to the Access4Jobs triage team.

Client Signature: _____ Date: _____

Parent/Guardian Signature: (If under 18 years old) _____ Date: _____

CLINICAL SECTION: This section must be completed by a licensed clinician.

Pertinent History / Hospitalizations _____

Current Treatment/Medication _____

Client's Strengths _____

Current mental status (symptoms)	Ability to handle responsibility
Able to tolerate full day of employment training	Motivation & cooperation
Ability to accept constructive feedback	Concentration/learning ability
Occupations/situations to avoid	Assaultive/violent history
Frustration tolerance	Judgement

Mental Health Primary Diagnosis(es) _____ BIS # _____

Comments: _____

*** Referrer or Co-signer must have one of these professional credentials: MFT, LCSW, MD, PsyD, or PhD (In Psychology)**

Referred by: (name & credential) _____ Signature _____

Co-Signature name: (if applicable) _____ Co-Signature _____

Agency/Address _____ Phone _____ Date _____

FAX this form to: 888-262-3988 Questions? Please call: Stephen Dempsey, BHS, 415-255-3664

http://bit.ly/SFVOC - electronic fillable version of Access4Jobs referral form

Rev. 4/16

City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. Failure **to provide all information marked with an asterisk(*) may invalidate this authorization.**

Name of Client*:_____ Date of Birth*: _____

I authorize ***RAMS Hire-Ability (415) 282-9675 1234 Indiana St.; San Francisco, CA 94107*** to disclose health
(Name, title, & address of person or organization)*

information obtained in the course of my diagnosis and treatment for the **purpose of:** ***Participation in Vocational Rehabilitation Program*** and shall be limited to the following types of information — I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law requires that recipients refrain from redisclosing such information except with my written authorization or as specifically required by law.

o Discharge Summary
o Assessment
o Treatment Plan of Care
o Physician's Orders
o Progress Notes
o Results of Lab Tests
o Results of Psychological or Vocational Testing
o Educational Assessment and Behavioral Reports (including school observation & educational testing)
o Substance Abuse Treatment
⊗ **Other (Specify)** ***Diagnoses, medications and exchange of information regarding participation and progress***

Send to*: ***RAMS Hire-Ability***
(Name, title, & address of person or organization authorized to receive the information)

My Rights: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to CBHS or other facility. My revocation will be effective upon receipt, but will not be effective to the extent that CBHS may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Expiration*: This authorization will automatically expire in 90 days from the date of execution unless a different end date or event is specified: _____**or immediately upon fulfillment.**
(date/event)

* _____	* _____	_____
Date	**Signature (Client/Patient/Parent /Guardian/Conservator)**	Relationship if not Client/Patient

_____ o Interpreter used _____
Witness (Required if Client/Patient unable to sign)

Notes:
* A separate authorization is required to authorize the disclosure or use of **psychotherapy notes**.
If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.