

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 May 1, we will do our best to conduct the phone interview by May 31 or sooner. A checklist has been provided below to ensure that all required documents have been submitted.

Please visit www.hire-ability.org for 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			
<i>Please complete all fields below</i>			
First Name:		Last Name:	
Phone:		Email:	
Address:			

II. Training Track Preference	
<i>Please check only one box</i>	
Which program track do you most prefer?	<input type="checkbox"/> Desktop <input type="checkbox"/> Help Desk

III. Program Requirements	
<i>Note: You must answer Yes to all of the following questions in order to be eligible for this program</i>	
1. Are you currently a San Francisco resident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you a High School graduate or equivalent (GED)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently receiving services through BHS?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
4. Are you able and willing to commit to the full nine month training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Can you commit to 7-12 hours per week? (Mon-Fri, between 8:30am and 5pm)	<input type="checkbox"/> Yes <input type="checkbox"/> No
* If you are not currently receiving BHS services, call (415) 503-4730 if you are interested in linkage to services.	

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

V. References			
<i>Note: A clinical reference is required</i>			
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. **Why do you feel you are a good match for the program? (include relevant information about your background)**
2. **Why are you interested in joining this program?**
3. **How do you hope to utilize skills you will learn in this program?**
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?**

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VI. Personal Statement
Continued

Empty text area for the personal statement.

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Completed Application Checklist

Please do not submit your application until you have completed all of the following:

- 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)
- Your personal statement
- Attach **Vocational Referral (Access4Jobs)** form *(must first be completed and signed by your clinician)*
- 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.

The following documents are also required for enrollment, but may be submitted separately from the application; however, we will need to receive them before you can be accepted into the program:

- Copy of your most recent **diploma** or **transcript** (official/unofficial)

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:

Attn: Vocational IT Manager
Hire-Ability
1234 Indiana Street
San Francisco, CA 94107

Alternatively, applications may be emailed or faxed:

Email: iability@hire-ability.org

Fax: (415) 920-6877

Note: If you are faxing your application, please call (415) 282-9675 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 Gender Non-Conforming
 Trans Female Trans Male Intersex
 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 _____

CONFIDENTIALITY NOTICE: This document (including any attachments) contains confidential and privileged information. Unless you are the addressee (or authorized to receive for the addressee), you may not read, copy, distribute, or disclose any information contained in this document. If you have received this in error, please immediately advise the sender, and permanently destroy all copies of the document and any attachments. Thank you for your cooperation.



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 _____ 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**

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/clinical information to be released by the referring source to the Access4JOBS triage team.

CLIENT SIGNATURE: _____ DATE: _____

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

Pertinent History / Hospitalizations _____

Current Treatment/Medication _____

Client Strengths: _____

Current mental status (symptoms):	Ability to handle responsibility:
Ability 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:	Judgment:

Mental Health Primary Diagnosis(es) _____ ICD10 Code: _____
 _____ BIS#: _____

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

Comments: _____

* Referred by: (name & credential) _____ Signature _____

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

Agency/Address _____ Phone _____ Date _____



**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*: _____

RAMS Hire-Ability (415) 282-9675

I authorize **1234 Indiana St.; San Francisco, CA 94107** to disclose health
 (Name, title, & address of person or organization)* **Participation in**

Vocational

information obtained in the course of my diagnosis and treatment for the purpose of: **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.

- Discharge Summary
- Assessment
- Treatment Plan of Care
- Physician's Orders
- Progress Notes
- Results of Lab Tests
- Results of Psychological or Vocational Testing
- Educational Assessment and Behavioral Reports (including school observation & educational testing)
- 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.