Kittitas County Developmental Disabilities (KCDD)
Job Foundations Application

Application Date:

Student's Name & Birthdate: Last Name | First Name | Middle Initial | DOB (MM/DD/YYYY)

Address: Street | City | Zip Code

Contact: Home Phone | Cellular | E-Mail

Own Legal Guardian? ☐ Yes ☐ No

Do you need an interpreter? ☐ Yes ☐ No **If yes, please indicate language or type:**

CONTACT INFORMATION OF PRIMARY SUPPORT PERSON: List personal contact in case of an emergency or for messages

Name | Relationship to student | Phone Number | E-Mail Address

Legal Guardian? ☐ Yes ☐ No

EDUCATIONAL STATUS

School Name | School District | Exit Year

Teacher Name | Phone Number | E-Mail Address

Are you currently a customer of:

Developmental Disabilities Administration (DDA)? ☐ No ☐ Yes**, Case Manager's Name:**

Division of Vocational Rehabilitation (DVR)? ☐ No ☐ Yes**, Counselor's Name:**

Are you receiving Social Security Benefits? ☐ No ☐ Yes

PROVIDER SELECTION (List the employment provider you wish to work with for this project**)**

Provider Name

Authorization

- I certify that the information provided is true to the best of my knowledge. I am also aware that the information I have provided is subject to review and verification and I may have to provide documentation to support this application.
  I allow release of this information for verification purposes and understand that it will be used to determine eligibility. Upon request, I will be provided information on equal opportunity and appeal rights and the Privacy Act of 1974.
- I authorize KCDD and/or Employment Provider to assist the Applicant with Job Foundations supports and activities to obtain employment in the community earning minimum wage or above.
- I authorize KCDD to contact me after termination of services to offer additional services and to inquire about the long-term outcomes of participation in the Job Foundations.
- I grant permission for Applicant to fully participate in educational, training, employment related counseling activities provided by KCDD and/or Employment Provider, including but not limited to participate in and to go on any education, work, or training related field trips or activities arranged by the KCDD and/or Employment Provider.

_____ Student Signature Date

_____ (If Applicable) Guardian Signature Date

Kittitas County Developmental Disabilities (KCDD)
Job Foundations Application

AGREEMENT FOR RELEASE OF INFORMATION

Student/Applicant Name:

Last Name | First Name | Middle Initial

I give permission to Kittitas County Developmental Disabilities program to contact the persons and/or agencies specifically listed below (this may include former employers, teachers, social service professionals etc…) to request information/documentation on my work skills, work history, or any other information relevant to the success of my participation in the Job Foundations Project and related activities. I understand that it may include standardized test results, transcripts, attendance records, performance reports and information from counselors, teachers, and other staff.

I authorize the Department of Social and Health Services, Developmental Disabilities Administration (DDA) to release information to the Kittitas County Developmental Disabilities program (KCDD). This exchange is authorized for information relevant to eligibility determination and coordination of service delivery and all information will be kept confidential.

Person/Agency	Documents exchanged	Phone contact/mtgs
Washington State Department of Social & Health Services Developmental Disabilities Administration (DDA)	☐Yes ☐No	☐Yes ☐No
Washington State Department of Social & Health Services Division of Vocational Rehabilitation (DVR)	☐Yes ☐No	☐Yes ☐No
Name of Public School	☐Yes ☐No	☐Yes ☐No
Name of selected Employment provider	☐Yes ☐No	☐Yes ☐No
If Applicable:		
Community College:	☐Yes ☐No	☐Yes ☐No
Adult Family Home Provider	☐Yes ☐No	☐Yes ☐No
Residential Services Provider:	☐Yes ☐No	☐Yes ☐No
Other:	☐Yes ☐No	☐Yes ☐No
Other:	☐Yes ☐No	☐Yes ☐No

I understand that any information will be treated confidentially and used only with the intent of facilitating my employment and/or community contribution goal/s. I also understand that I may terminate this release at any time. This release will automatically terminate 12 months from the date signed.

_____ _____

Student Signature Date (If Applicable) Guardian Signature Date