

## **Project HIRED AbilityOne Application Packet**

**Project HIRED (PH)** is a 501(c)(3) nonprofit organization established in 1978 with a mission “To assist individuals with disabilities to gain and to sustain employment.”

The AbilityOne Program, established by the Javits-Wagner-O’Day Act, provides employment opportunities for Americans with significant disabilities.

*This document contains the steps to apply for an AbilityOne position with Project HIRED.*

**Please note that all forms must be completed and returned as a single packet for an applicant to be considered for this program. Additional Packets are available at [www. projecthired.org](http://www.projecthired.org)**

## AbilityOne Application Process

**Interested applicants must complete all of the steps below to be considered for employment in an AbilityOne position with Project HIRED**

1. In order to apply for an AbilityOne position with Project HIRED the Applicant must first become a Project HIRED AbilityOne Candidate.
2. **The Applicant must:**
  - Complete Project HIRED AbilityOne Application
  - Complete Authorization for Release of Information Form
  - Provide a current resume
3. **The Applicant must also provide the following information from his/her medical doctor who is licensed MD, DO, or PHD:**
  - On the doctor's formal letterhead:
    - The applicant's medical diagnosis(es)
    - The doctor's contact information:
      - Professional stamp
      - License number
      - Medical Doctor's Signature
  - A completed Project HIRED AbilityOne Medical Accommodation Form
4. The completed Project HIRED AbilityOne packet must be sent to the Project HIRED Corporate office:

**NOTE: All information must be mailed, emailed or faxed as one complete packet to:**

Project HIRED AbilityOne Program  
1401 Parkmoor Avenue, Suite #125  
San Jose, CA 95126  
Or  
Secure Fax: 1-408-343-7054  
Email: [abilityone@projecthired.org](mailto:abilityone@projecthired.org)

5. The AbilityOne Program Representative will review all Applicant paperwork
6. If the applicant is deemed a possible AbilityOne Candidate then the AbilityOne Program Representative will contact the applicant to set up an Accommodation Assessment.
7. If the Applicant meets the AbilityOne Assessment criteria then the Applicant will be approved as a Project HIRED AbilityOne Candidate.

8. Project HIRED AbilityOne Candidates will then be eligible for any Project HIRED AbilityOne open position.

**NOTE: Becoming a Project HIRED AbilityOne Candidate does not guarantee employment.**

9. Project HIRED's AbilityOne Candidate will be called in to interview at the discretion of the Supervisors of Project HIRED's AbilityOne contract sites.

**NOTE: Being interviewed does not guarantee employment.**

10. For those AbilityOne Candidates offered employment, it is contingent upon passing the required security background check.
11. Project HIRED AbilityOne Candidate's information will be kept on file for up to one year.

## Project HIRED AbilityOne Packet checklist

- Project HIRED AbilityOne Application Form
- Authorization Release of Medical Information form
- Project HIRED AbilityOne Medical Evaluation (signed by: MD, DO, or PHD)
- Medical Doctor's Formal Letter with Diagnosis(es), Signature, License #, Professional Stamp
- Resume



# ABILITYONE APPLICATION

***(All questions require a response for consideration)***

## **Personal**

[Mr] [Mrs] [Ms] Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_ First Name: \_\_\_\_\_

SSN: (last 4 digits ONLY) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Ethnicity:  Hispanic  Native American  Alaskan  Asian  African American  Hawaiian  Pacific Islander  Caucasian  M. Eastern  Other/Declined

Gender:  Male  Female

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  TTY Email: \_\_\_\_\_  Personal  Business

Veteran (Check all that apply)  No  Yes  Vietnam  Special Disabled (30%+)  OEF  OIF

Criminal convictions in last 7 years?  Yes  No

How did you learn about Project HIRED AbilityOne program?  Family/Friends  Newspaper  One-Stop/EDD  Job Fair  Dept. of Rehab  
 Walk-in  Website  Project HIRED Event  Staff Member  Returning Client  Vet Vocational Rehab Other: \_\_\_\_\_

## **Education and Language**

Attending school:  Yes  No Education completed:  GED  HS  Associate  Bachelor  Masters  Doctorate  Other \_\_\_\_\_

Primary language: \_\_\_\_\_ Second language: \_\_\_\_\_

Certifications: \_\_\_\_\_

## **Disability Information**

Primary disability description: \_\_\_\_\_

Secondary disability description (if applicable): \_\_\_\_\_

Describe accommodation(s)

Mobility: \_\_\_\_\_  
\_\_\_\_\_

Communication: \_\_\_\_\_  
\_\_\_\_\_

Work Tolerance: \_\_\_\_\_  
\_\_\_\_\_



# ABILITYONE APPLICATION

**(All questions require a response for consideration)**

Describe accommodation(s) (cont.)

Work Skills: \_\_\_\_\_  
\_\_\_\_\_

Self-Care: \_\_\_\_\_  
\_\_\_\_\_

Self-Direction: \_\_\_\_\_  
\_\_\_\_\_

Work Restrictions: \_\_\_\_\_  
\_\_\_\_\_

## **Desired Employment**

Job category: \_\_\_\_\_ Job title: \_\_\_\_\_

2nd Job category: \_\_\_\_\_ Job title: \_\_\_\_\_

Desired pay \$ \_\_\_\_\_ per \_\_\_\_\_ Desired hours per week: \_\_\_\_\_  
[ ] Perm [ ] Temp [ ] M-F [ ] Weekends [ ] Days [ ] Swing [ ] Grave [ ] Any shift

## **Employment History**

[ ] Never Employed (you may skip this section)

Start with your most recent job:

Last Job Title: \_\_\_\_\_ Company \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Start Date: \_\_/\_\_/\_\_ End Date: \_\_/\_\_/\_\_ or still employed [ ]

Pay rate \$ \_\_\_\_\_ per [ ] Hour [ ] Week [ ] Month [ ] Year Reason for leaving: \_\_\_\_\_

Job Title: \_\_\_\_\_ Company \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Start Date: \_\_/\_\_/\_\_ End Date: \_\_/\_\_/\_\_

Pay rate \$ \_\_\_\_\_ per [ ] Hour [ ] Week [ ] Month [ ] Year Reason for leaving: \_\_\_\_\_

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date Completed**



1401 Parkmoor Ave., Ste. 125  
 San Jose, CA 95126  
 Phone: 1-408-557-0880  
 Fax: 1-408-343-7054  
 Web: www.projecthired.org

**AUTHORIZATION FOR RELEASE OF INFORMATION**

*Applicant: Please initial next to each area in which you would have education, vocational, work-search or disability-related areas. This form, and the information obtained from these sources, is STRICTLY CONFIDENTIAL.*

I hereby request and authorize the release to Project HIRED the following types of information pertaining to me:

Requested Information	Applicant's Initials
School	_____
Employment History	_____
Psychological Testing/Reports	_____
Psychiatric Evaluations	_____
Hospital & Medical Records Reports	_____
Department of Rehabilitation Records	_____
Other <i>Please Specify:</i> _____	_____

Last Four Digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Applicant's Full Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

***This release is valid for one year.***

The individual listed above has applied to Project HIRED for job placement services and has signed this authorization for release of information. Project HIRED is a free employment service that assists disabled persons in finding employment. There is no fee to the employer or applicants. **We do not have the funds to pay doctor fees to obtain client health records.** Please contact this office if you are unable to send records or if you have any questions regarding Project HIRED.

Thank you,  
 Project HIRED Staff

Please return completed form to Project HIRED. The information contained herein is considered strictly private and confidential.

**Project HIRED Verification of Disability for Job Placement Services**

**Dear Physician:**

**Project HIRED** is a 501(c)(3) non-profit organization with a mission to assist individuals with disabilities to gain and to sustain employment. Founded in 1978, Project HIRED was created with the commitment to empower individuals with disabilities to become independent job seekers and to focus on ability. Project HIRED's AbilityOne Program, established by the Javits-Wagner-O'Day Act, provides employment opportunities for Americans with significant disabilities.

Your patient listed below is applying to become a Project HIRED AbilityOne candidate. We would appreciate your assistance in providing relevant information about your patient's disability as it relates to employment. **Project HIRED is required to have a verification of disability signed by a licensed medical doctor as well as a formal letter stating all diagnoses in order for the candidate to be considered for employment.**

If you have concerns regarding the release of this information, you may contact us directly at 1-408-557-0880 or info@projecthired.org

**Thank you for your time.**

Sincerely,

**Project HIRED**

***Physician Checklist***

- Letter on physician's letterhead stating patient's diagnoses
- Completed Medical Evaluation form

**JOB SEEKER: PLEASE SIGN HERE BEFORE FORWARDING  
TO YOUR PROVIDER:**

I, \_\_\_\_\_ give my permission to release medical  
*(print name)*

and/or disability related information to Project HIRED for the purposes of defining me as disabled to qualify for employment services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Project Hired Verification of Disability for Job Placement Services**

**MEDICAL EVALUATION**

Patient Name: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

It is our goal to assist your patient by providing him/her with employment, education, training, and opportunities for personal growth as an interim step in the rehabilitation process. He/she states that they have a documented disability that has prevented him/her from finding employment opportunities. Please complete this form with as much detail as possible.

***Please note that this form must be signed by a licensed medical doctor (M.D.)***

**WORK-RELATED LIMITATIONS**

Date of examination on which this medical information is based: \_\_\_\_\_

Date of next evaluation to determine patient's continued work ability: \_\_\_\_\_

**In terms of working for paid competitive employment, check what describes the patient's current health situation at this time:**

**Please indicate the all of the patient's medical diagnoses that require work modifications and/or limitations:**

- Patient is able to work with limitations and/or modifications at least 10 hours per week.  
*The patient has at least one permanent significant disability.*
- Patient is unable to work. **(No need to continue completing form.)**

Primary Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

Other Diagnosis \_\_\_\_\_

**Additional accommodation information you may deem appropriate that relates to this patient's disability:**

\_\_\_\_\_  
 \_\_\_\_\_

**By Signing this form I am certifying that the patient is able to work with limitations at least 10 hours per week.**

\_\_\_\_\_  
**Signature of M.D.**

\_\_\_\_\_  
**License Number**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Date**





**Project Hired Verification of Disability for Job Placement Services**

**The following section is not required but is helpful for Project Hired to better serve the applicant**

Check all areas for which the patient requires accommodations:

**Mobility**

- Lifting objects greater than \_\_\_\_\_ lbs.
- Sitting for more than 1 hour at a time
- Standing for more than 1 hour at a time
- Walking distances greater than 50 feet
- Climbing 4 to 6 steps
- Environmental
  - Extreme cold
  - Extreme heat
  - Fumes, odors, dusts
  - Loud noises
- Commuting
  - Must travel with assistance/attendant

Driving an automobile

- Visual
  - Spatial/perceptual relationships
  - Severe limitation of depth perception
  - Severe limitation in near acuity
  - Severe limitation in distance acuity
  - Severe limitation in field of vision

Other: \_\_\_\_\_

**Communications**

- Inability to acknowledge that information is understood
- Poor verbal communication skills
- Difficulty asking for help
- Difficulty expressing when hurt, sick, or in pain
- Inability to follow simple written instructions
- Inability to follow simple verbal instructions
- Inability to ask or answer questions
- Difficulty interacting with fellow employees
- Other: \_\_\_\_\_

**Self-Care**

- Eating / feeding
- Assistance with medical issues / administering medication
- Prone to self-injurious behaviors
- Inability to manage bodily functions
- Needs assistance / reminders / prompting with personal hygiene and dressing appropriately
- Other: \_\_\_\_\_

**Project HIRED Verification of Disability for Job Placement Services**

**Self-Directions**

- Inability to make simple decisions
- Inability to cope with or solve problems
- Inability to remember sequence of tasks
- Easily influenced, taken advantage of
- Inability to understand boundaries
- Inability to self-motivate
- Inability to get to work on time
- Lack of organizational skills
- Poor judgment
- Inability to understand consequences
- Lack of initiative to move from one task to another
- Easily confused
- Inability to work without supervision
- Need for extensive prompting
- Other: \_\_\_\_\_

**Work Skills**

- Extensive job coaching needed to master the job
- Need for extensive re-training
- Requires pictorial aids / references
- Inability to do multi-step tasks
- Inability to carry out previously learned tasks
- Inability to perform tasks in correct sequence
- Other: \_\_\_\_\_

**Work Tolerance**

- Inability to physically or emotionally withstand a work week
- Excessive absenteeism / poor attendance
- Frequent need for time off for therapy / appointments , hospitalizations
- Substandard work productivity
- Inability to tolerate distractions
- Frequent or long breaks needed
- Easily distracted
- Easily overwhelmed
- Inconsistent work performance
- Difficulty accepting constructive criticism
- Inability to deal with changes
- Inability to focus
- Issues with stamina, fatigue
- Other: \_\_\_\_\_

**AbilityOne Doctor's Letter Example**

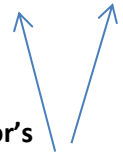
NOTE: This is an example only. Actual letter must be on physician's letterhead.



Doctor's mailing address

Date

Letter must be on **doctor's** formal letterhead



State patient name and all applicable diagnosis titles (**medical billing codes not necessary**).

Signature of licensed medical doctor  
(MD, DO, or PHD acceptable)

Doctor's professional stamp with  
license number included

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- Resume