



GENERAL PROGRAM APPLICATION

(rev. 9/2018)

KEEP THIS PAGE!!!

What **Work and Activity Program**

Who Adults 18 years old and older with intellectual disabilities

Where 2845 Thousand Oaks, San Antonio, Texas 78232

Start Time: Monday through Friday - 9:00 AM (open at 8:00am)

End Time: Monday through Friday - 4:00 PM (close at 5:00pm)

Please note that Texas Foundation of Hope is not responsible for clients/members who arrive before the Foundation opens (8:00a.m.) nor is Texas Foundation of Hope responsible for clients/members who remain after the Foundation closes (5:00p.m.)

Late fee: Please note that Texas Foundation of Hope will charge a late fee of \$10.00 for every 15-minute increment a consumer remains after 5:00 pm.

Application: Please fill out the attached forms. Only completed forms will be considered. A processing fee of \$50 is required with each application prior to consideration and is non-refundable.

The Texas Foundation of Hope (TXFH) Activity Program is designed for persons 18 years of age & older who:

- 1) have intellectual disabilities,
- 2) are emotionally and physically well, and
- 3) shows behavior within acceptable guidelines.

Please note:

- 1) TXFH **does not** accept participants requiring one-on-one supervision and participants requiring such supervision will be withdrawn.
- 2) Participants with controlled seizure disorders, cerebral palsy, autism spectrum disorders and other physical disabilities will be individually evaluated for admission.
- 3) Medical conditions and equipment which TXFH cannot accommodate include G-tubes, feeding pumps, baclofen pumps & toileting assistance. **There is no on-site nurse.**
- 4) Smoking (tobacco, smoke-less, and e-cigarette type) is not allowed at Texas Foundation of Hope (TXFH) and no accommodations are made for smokers. If a prospective participant cannot comfortably go without smoking, then he or she *should not apply*.

Please mail application with a \$50 fee to:

**Texas Foundation of Hope
ATTN: BEATRICE STEPHENS
2845 Thousand Oaks
San Antonio, TX 78232**

TXFH GENERAL PROGRAM APPLICATION

I affirm by signature below that my participant for whom this application is made meets the health and behavior guidelines described on the cover page. If misrepresentation is made regarding my participant's health or behavior, or if my participant becomes ill enough, or engages in behavior deemed serious enough to warrant dismissal, he or she may be dismissed from the Program. I understand that if my participant is dismissed due to health or behavior considerations, it is my sole responsibility to pick up my participant on the day I am notified and that no refund will be made for the session from which my participant attends.

Attach
Photo
Here

Parent/Legal Guardian _____

Application Date _____

Start Date: _____

TXFH Staff Only

Participant Information

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____ County _____

Participant's Phone _____ Primary Diagnosis/Disability _____

Date of Birth _____ Age at Program _____ Height _____ Weight _____

Gender: ☐ Male ☐ Female:

Social Security Number _____ Date of Last Physical Exam _____

Insurance Carrier _____ Group Number _____ Member Name _____

Primary Physician _____ Phone _____

My Participant does **NOT** have insurance _____ Medicaid No. _____

Limitations of Participants' Disability: _____

If Down Syndrome, stable for atlanto-axial subluxation (AAS)? Yes No

Most recent cervical x-ray for AAS (date) _____ (city) _____

Physician _____ Phone _____

Applicants are required to attend a minimum of 4 days.

Previous Day Habs and Previous Employment

Name _____ Date _____ Reason for Leaving _____

Name _____ Date _____ Reason for Leaving _____

Name _____ Date _____ Reason for Leaving _____

Name _____ Date _____ Reason for Leaving _____

Name _____ Date _____ Reason for Leaving _____

Name _____ Date _____ Reason for Leaving _____

Service Provider

(If applicable)

Name of Service Provider (Agency/Company): _____
Address: _____
Business Phone #: _____ Contact Person: _____
Case Manager / QMRP: _____ Office Phone #: _____ Cell #: _____
Name of Group Home / Facility: _____
Address: _____
Residence Manager: _____ Phone #: _____
Nurse / LVN: _____ Office Phone #: _____ Cell #: _____
Social Worker: _____ Office Phone #: _____ Cell #: _____
Service Provider Accounts Payable contact and phone #: _____
Who is legally responsible for payment of day hab fees? _____

Payroll: Where will consumer payroll checks be mailed?

If given on-site, may we give the check directly to the applicant? Yes No

NOTE: In accordance with Texas law, all members must go through a Texas Work Force Commission, (TWC) certification process before we are allowed to pay them. (See TWC Packet)

Parent/Guardian Information

Name _____ Relation to Participant _____
Who is the Applicant's LEGAL Guardian? _____
Address _____
City _____ State _____ Zip _____ County _____
Day Phone _____ Night Phone _____
Cell Phone _____ Email _____

Emergency Contact Person (This person MUST be available during the Program hours)

Same as Parent/Guardian Information? Yes _____ No _____ (If no, please complete the information below)

Name _____ Relation to Participant _____
Address _____
City _____ State _____ Zip _____ County _____
Day Phone _____ Night Phone _____
Cell Phone _____ Email _____

Guardian/Family Contact Information (if different):

Legal Guardian's Name: _____
Address: _____
Home Phone #: _____ Work #: _____ Cell #: _____
Type of Guardianship: _____
Contact in case of emergencies: _____ Yes _____ No
Please provide a copy of Legal Guardianship paperwork

Is the consumer his or her own guardian? Yes _____ No _____ (If yes, continue)

I, (consumer) _____ give permission for The Texas of Hope, aka TXFH, to
contact
My Case Manager or Direct Care Staff about programmatic issues while attending TXFH.

Consumer Signature

Transportation

Will this applicant use *VIA Trans* for transport? YES NO ID No. _____

If not who will transport them to the TXFH site? _____

(May change method of transportation after becoming a member if needed)

_____ Please initial that you understand that Texas Foundation of Hope assumes no responsibility or liability
for any client/member who arrives prior to TXFH opening at 8:00 a.m.

_____ Please initial that you understand that Texas Foundation of Hope assumes no responsibility or liability
for any client/member who remains on campus after TXFH closes at 5:00p.m.

Immunization

Proof of immunizations required for Participant 16
and under. Dates of Illness or Immunization:

Polio _____ type: _____ Measles-Red _____ Rubella-German _____
Diphtheria/Pertussis _____ Tetanus _____ HIV Virus _____ Chicken Pox _____
Shingles _____ Influenza _____
Other(specify): _____

Current Medication Regimen

(Please list **all medications** taken on routine basis, **DAY OR NIGHT**; prescription and over-the-counter)

Medication: _____ Dosage: _____ Time of Day: _____
Reason Taken: _____
Medication: _____ Dosage: _____ Time of Day: _____
Reason Taken: _____
Medication: _____ Dosage: _____ Time of Day: _____
Reason Taken: _____
Medication: _____ Dosage: _____ Time of Day: _____
Reason Taken: _____
Medication: _____ Dosage: _____ Time of Day: _____
Reason Taken: _____
Medication: _____ Dosage: _____ Time of Day: _____
Reason Taken: _____

Permission to give over-the-counter medications (OTC) on as needed basis:

Please initial each medication or its generic equivalent that may be administered to your Participant. Please check “No” or “YES” beside each medication AND initial. **NOTE:** TXFH does not have a nurse on duty/staff. Any medication needed during the program hours will need to be brought by the member and taken by the member on their own. TXFH Staff is not responsible for the medication nor the administration of the medication in any form.

_____ (initials) YES NO - Tylenol _____ (initials) YES NO - Motrin/Ibuprofen _____ (initials) Yes No - Benadryl

_____ (initials) YES NO - Other: _____

Allergies:

My Participant is allergic to: _____, _____, _____, _____

How is the reaction recognized? _____

Does your Participant carry a required Epi-Pen? _____

Special Dietary Concerns: _____

TXFH Permissions

THIS APPLICATION CANNOT BE PROCESSED UNLESS ALL QUESTIONS HAVE BEEN INITIALED

Under Texas law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Please initial as recognition of this equine statement. _____

Yes No

- ____ ____ I give my Participant permission to attend the TXFH Program. He/she may participate in all activities. **ANY EXCEPTIONS ARE:** _____
- ____ ____ I understand that opportunities may be available for participants to interact with live vaccinated animals. I give my Participant permission to participate in those activities.
- ____ ____ I authorize TXFH staff and volunteers to share, without restriction, my participant's health information and medical records with any person (whether or not affiliated with Texas Foundation of Hope) as may be reasonably necessary in order to facilitate the care of my participant.
- ____ ____ If emergency treatment is necessary, I give permission for my participant to be brought to the nearest emergency room by ambulance or helicopter for treatment. I authorize TXFH to release all records necessary for insurance purposes so that my insurance company can be billed for the visits, lab tests, and/or x-rays if necessary.
- ____ ____ In the event that participant has no insurance, I will be responsible for his/her medical bills.
- ____ ____ I understand TXFH allows parents/guardians to call and check the health status of their participant or speak with a staff in regard to their participant's wellbeing.
- ____ ____ I give TXFH permission to use my participant's name, photograph, or video image for publicity purposes.
- ____ ____ I understand that TXFH has a designated Lost and Found. However, if I or my participant leaves my participant's items anywhere, I will not hold TXFH responsible for them. **THIS INCLUDES ALL ELECTRONIC DEVICES, INCLUDING CELL PHONES, GAME, IPODS, ETC. Members are encouraged to leave these at home.**
- ____ ____ Did you fill out the TWC-VRS Career Counseling Packet? **This Packet Must be filled out. All Work/Tasks performed before attending the career counseling conducted by TWC is completed is considered training and will not be paid for.**

Equipment Use

- ____ ____ My participant may use the laminating machine after being trained by TXFH.
- ____ ____ My participant may use the paper cutter after being trained by TXFH.
- ____ ____ My participant may use box cutters (Utility Knife) after being trained by TXFH.

I, _____, guarantee that the information on this application is accurate and hereby release and forever discharge TXFH, its members, employees, and volunteers from any liability, suit, claim, or demand, whether for personal injury to myself or members of my family including minor children, or for property damage which result from any participation in the work program.

Participant Signature _____ Date _____

Parent/Legal Guardian _____ Date _____

TEXAS FOUNDATION OF HOPE
Behavior Checklist for New Applicants

Each person will be evaluated on a one-to-one basis. Behaviors listed below that occur with enough frequency to disrupt normal program operations may result in a member's admission denial or future dismissal.

	Yes	No
1. Wanders off or runs away	_____	_____
2. Oppositional toward staff	_____	_____
3. Throws objects, bites or scratches	_____	_____
4. Displays emotional outbursts	_____	_____
5. Tantrums when angry or frustrated	_____	_____
6. Physically fights with others	_____	_____
7. Injures self	_____	_____
8. Steals or destroys property	_____	_____
9. Uses electronics inappropriately	_____	_____
10. Uses foul or inappropriate language or talks constantly	_____	_____
11. Continually complains of unfounded illness	_____	_____
12. Hallucinates to the point of dysfunction	_____	_____
13. Needs assistance for toileting needs	_____	_____
14. Does not respond to authority	_____	_____
15. Difficulty adjusting to new environment	_____	_____
16. Difficulty working with peers	_____	_____
17. Needs one-on-one supervision	_____	_____
18. Demonstrates sexual advances toward others	_____	_____
19. Taunts or bullies others	_____	_____
20. Requires medication to control behavior	_____	_____

Explanation & date of last occurrence for any of the above that were answered "yes":

***I/we have read these behaviors and understand that such behaviors will not be tolerated at TXFH.**

_____	_____	_____
Applicant's Signature	Parent/Guardian's Signature	Date Signed

Likes / Dislikes

Please identify specific likes / dislikes the applicant may have (i.e. dislikes loud noises; likes painting)

LIKES

DISLIKES

CONSENT / RELEASE FORM

REVIEW THE FOLLOWING FORM TAKING INTO CONSIDERATION THE PARTICIPANT MAY BE INVOLVED IN ONE OR MORE OF THE ACTIVITIES LISTED BELOW. WE ASK THAT YOU AS THE PARTICIPANT, LEGAL GUARDIAN OR PARENT OF A MINOR MAKE A DETERMINATION ON EACH OF THESE ISSUES AND INDICATE YOUR RESPONSE APPROPRIATELY. THIS FORM SHOULD BE COMPLETED AT THE TIME OF ADMISSION AND AT LEAST ANNUALLY THERAFTER.

I, _____ give or do not give (circle one) my consent/permission for
(Legal Guardian/Parent/Adult Participant)

_____ on each of the following issues:
(Participant)

PHOTOGRAPHS / VIDEOS

_____*YES* _____*NO (initial one)*

- 1) Consent/permission for photographs to be used for programming purposes in the classroom, on posters or in other participant's communication books.
- 2) Consent/permission for photographs or videos to be used by the Texas Foundation of Hope to portray or promote TXFH activities.
- 3) Consent/permission for photographs to be used on the Texas Foundation of Hope publications and brochures.
- 4) Consent/permission for photographs to be used on the Texas Foundation of Hope Website.
- 5) If consent/permission for photographs or videos is given, I also give my consent/permission for the participant's first name to accompany the photograph or videos.
- 6) If consent/permission for photographs or videos is given, I also give my consent/permission for the participant's first and last name to accompany the photograph of videos.

PARTICIPATION IN OUTINGS / FIELDTRIPS and EMERGENCY TRANSPORT

_____*YES* _____*NO (initial one)*

- 1) Consent/permission to participate in community outings and fieldtrips (i.e. shopping, movies, parks, bowling, etc.) after given trip details and confirmation of attendance
- 2) If consent/permission to participate in community outings and fieldtrips is given, I also give my consent/permission for TXFH staff to transport the participant.
- 3) In the event of a medical, facility, environmental or natural disaster emergency, I also give my consent/permission for TXFH staff to transport the participant.

RELEASE OF CONFIDENTIAL INFORMATION

_____*YES* _____*NO (initial one)*

- 1) Consent/permission for the participant's confidential information to only be shared with TXFH staff for programming purposes.
- 2) 2) Consent/permission for the participant's confidential information to be shared with the participant's Service Coordinator, Case Manager, QMRP or Provider.
- 3) 3) Consent/permission for the participant's confidential information to be shared with (Please Indicate Who):

Name: _____ Relationship: _____

MEMBER AGREEMENT TO PARTICIPATE

Parent or Guardian: Please read carefully and **initial** by each Agreement:

1. New Member agrees to follow rules as specified during orientation. _____
2. Member will be respectful to staff and other Members. _____
3. Member will not use foul language while at the Foundation or during transportation or community activities. _____
4. Member will not use tobacco products, smokeless tobacco products, e-cigarette type products, illegal or non-prescribed drugs or alcohol during program hours & sponsored activities. _____
5. Member will remain on the premises until parent or guardian arrives for pickup or VIA-transportation. _____
6. Member will not exhibit nudity, exposure, or demonstrate sexual acts at any time, nor via their cell phone, laptop or electronic device, nor when possessing written materials. _____
7. Member will not physically harm, tease, or intimidate another Member or staff at any time. _____
8. Member will engage in meaningful work or activity while at TXFH, or as directed by staff. _____
9. Member is asked to inform staff IMMEDIATELY of any unusual, illegal, unsafe, or prohibited behavior by another Member. _____
10. Member will be responsible for any personal items brought to the Foundation, including: purses, wallets, cameras, phones, electronics, ear phones or food items. These items should not be shared for health and safety reasons. _____
11. Members will not bring weapons, knives, guns, etc on to the TXFH property at any time. Violation could result in suspension from the program. _____

Members will be counseled for 1st and 2nd offenses. Further consequences for infractions of any of the above rules will result in suspension (up to 3). To return, parent or guardian must attend a staffing w/ the TXFH Executive Director (or designee). After the third suspension the member will be released from the Texas Foundation of Hope program and will not be allowed to return. Should the member decide to leave voluntarily they may reapply (new application process) after six months. Readmission will be at the discretion of the Admission Committee.

New Member

Parent or Guardian

Date Signed

Receiving TXFH Staff

Please Read & Sign

Permission to Obtain Medical Treatment: I give my consent by signature below for medical treatment to be obtained for my Participant by a representative of TXFH in the event I (or my designee) am unable to be reached.

Agreement to Pay for Medical Treatment: I understand that in the event of a medical emergency affecting my Participant, EMS may be called, and my Participant may undergo hospitalization and/or treatment. I agree to assume all costs associated with such summoning of emergency medical care, hospitalization, and treatment, and I hold Texas Foundation of Hope, its staff, Board of Directors, and volunteers harmless for any liability, medical or financial, arising from such.

Participant Signature _____

Date _____

Parent/Legal Guardian Signature _____

Date _____



----- cut here

KEEP THIS PART FOR YOUR RECORDS



Main Office
210.265.3351

FAX
877.696.0497

Beatrice Stephens

Executive Director

beatrice@sathgroup.com

Frank Vernon

Admissions

Frank@texasfoundationofhope.org

Frank Vernon

Tour Guide

Frank@texasfoundationofhope.org

Sarah Molina

Activity

Sarahm@texasfoundationofhope.org



What do I do now that I have completed the application?

- 1.) Call Texas Foundation of Hope at 210-265-3351 and schedule a tour with Admissions. Please bring your completed application and application fee to the tour. All tours are scheduled by appointment only. Please note that the application must be completed before it can be accepted by Texas Foundation of Hope and application fee needs to be submitted at the same time as the application.
- 2.) You will be notified no more than 10 days after application has been accepted unless otherwise instructed by Texas Foundation of Hope of the acceptance or decline of admission into the program as a potential member.
- 3.) Start date for the two-week trial will be arranged (Mondays) for the potential member. At the end of the two-week trial an evaluation by TXFH Staff will be made as to the potential members "fit" into the program.
- 4.) If it is determined that the potential member is a good "fit", then they will continue to attend as agreed upon in application. If it is determined that the potential member is not a good "fit" into the program, then they will no longer attend Texas Foundation of Hope.

Thank you for your interest in Texas Foundation of Hope.

TWC – VRS
Career Counseling
2018
Packet



Recently, this packet was either mailed or presented to you in person. The packet contains documents that are MANDATORY by law (please see below). Texas Foundation of Hope is required to maintain the completed packet or the completed refusal on file and provide the opportunity for our consumers to receive Career Counseling. All documents or refusals are due no later than April 15, 2018. Please note that effective immediately, consumers will not be paid until documents have been received and Career Counseling has taken place.

This packet of documents pertains to recently passed federal legislation, the Workforce Innovation and Opportunity Act (WIOA), Public Law 113-128, passed by Congress in July 2014 **and directly affects the individual for whom you hold guardianship.**

The WIOA requires individuals who wish to continue, or start to earn subminimum wage or piece rate to receive 'Career Counseling' and, depending on their age, certain other services from Texas Workforce Solutions-Vocational Rehabilitation Services (TWS-VRS). TWS-VRS is the state agency that assists individuals with disabilities in achieving competitive, integrated employment. Please review the documents in the Career Counseling packet. If you are comfortable with the information, please sign and date next to "Guardian" and return to the Sheltered Workshop, Day Habilitation or Facility that sent you the packet. If you have questions about the Career Counseling session, the documents and TWS-VRS' role in this new federal law please contact Sara Kendall at (512) 936-3539.

TWS-VRS welcomes you to attend the Career Counseling session if you are available. To find out when the session is scheduled, please contact us at Texas Foundation of Hope, (210) 265-3351.

As per the WIOA you, or the individual for whom you are the Guardian, can refuse to participate in Career Counseling or other mandated activities in the WIOA, but the individual will not be able to earn subminimum wage or piece rate. **Refusal to sign these documents will mean that TWS-VRS cannot do Career Counseling, and the individual for whom you hold guardianship will not be able to continue to earn subminimum wage.**



To find out more about TWS-VRS copy this URL into an internet browser <http://www.twc.state.tx.us/programs/vocational-rehabilitation-program-overview> or call the Texas Workforce Commission Vocational Rehabilitation Inquiries Line at (800) 628-5115.

If you have questions about the WIOA and its requirements, please contact the local Department of Labor Wage and Hour Division office nearest you. These offices can be located by copying this URL into an internet browser:

<https://www.dol.gov/whd/america2.htm>, or by calling the Department of Labor's Wage and Hour Helpline at (866) 487-9243.

General Instructions

The Career Counseling Datasheet is to be completed by the 14c Employer and provided to the VRS staff providing the Career Counseling to the employee. Complete all spaces on this form.

14c Identification Information

Organization Name:

Address:

City:

County:

State:

Zip:

Phone 1:

Contact Name:

Date Employment for Individual below began:

Date:

Personal Identification Information

Last Name:

First Name:

Middle Name:

Date of Birth:

Social Security Number:

Address:

Address 2:

City:

County:

State:

Zip:

Phone 1:

Type:

Phone 2:

Type:

Phone 3:

Type:

Phone 4:

Type:

Video Relay IP Address:

E-mail Address:

Name of Guardian:

Guardian's Address:

Guardian's Telephone Number:

Type:

General Instructions

The Career Counseling and Information and Referral for Individuals – Subminimum Wage Form (Form) is a document that demonstrates Texas Workforce Solutions–Vocational Rehabilitation Services (TWS-VRS) has provided career counseling and information and referral services to individuals with disabilities who are earning subminimum wage. Two copies of the Form must be completed, signed, and dated for each individual provided with these services. One original copy of the Form is given to the individual or their guardian or legal representative, and TWS-VRS retains an original copy.

The Form is designed to be used in conjunction with the Career Counseling Workbook (Workbook). TWS-VRS staff reviews the Workbook for each person working for subminimum wage. Please follow the directions below:

1. Complete the participant's name and write in the date the meeting is taking place on page 1 of the Workbook.
2. Counsel the participant by reviewing the Workbook with the participant. Make notes on the Workbook for them if they provide information about what they like.
3. Complete the Person Identification Information section of this form.
4. Complete the 14c Employer Information section of this form.
5. Ask the person Question #1 in the Questions About Work section of this form.
 - a. If the person states they **do not** want to work someplace in the community for at least minimum wage (Question #1):
 - i. Explain the Career Counseling and Information and Referral section of this form.
 - ii. Obtain the Signatures and Dates in that section of this form.
 - iii. Complete the Method of Delivery Section in this form.
 - iv. Provide the Information and Referral page to the person and/or the guardian.
 - b. If the person states they **do** want to work someplace in the community for at least minimum wage (Question #1)
 - i. Ask the person the rest of the questions (2-6) and complete this section of this form. If the person has a current VR case with TWS-VRS, please note information in the "Comments" field.
 - ii. Explain the Career Counseling and Information and Referral section of this form.
 - iii. Obtain the Signatures and Dates in that section of this form.
 - iv. Complete the Method of Delivery Section in this form.
 - v. Provide the Information and Referral page to the person and/or the guardian.
6. It is required by law to ensure the "method of delivery" is marked for the person and, if appropriate, the guardian or legal representative.
7. Make a copy of the Form so that both the person or guardian and TWS-VRS staff have a copy. If no copy machine is available, complete a second copy of the Form.
8. Provide the person with the Thank You card.

Person Identification Information

Person Name:

14c Employer Information

14c Employer Name:

Questions About Work

1) Do you want to work in the community for at least minimum wage?

If yes, please complete the question 2-7 below ☐ Yes

If no, please explain in the Career Counseling and Information and Referral section of this form and then have the parties complete the Required Signatures and Dates section of this form. ☐ No

2) How many days a week do you work now?

3) How many days a week do you want to work in the community?

4) How many hours a day can you work?

5) Where do you want to work?

6) Did you see any jobs in the Workbook you might like?

☐ No

☐ Yes – please provide information in the comments section on which jobs might be of interest

7) Do you want information on how to apply for services with TWS-VRS?

☐ Yes

☐ No

Comments: (Please use this space to note if participant has a current case with TWS-VRS, if they are receiving transition services through school or TWS-VRS, if they are Pre-ETS, or other information, if known).

Career Counseling and Informational and Referral

1. If you want to work in the community making minimum wage or more, TWS-VRS can take an application for services from you and may be able to assist you. Please look on page 3 under the section "Local Employment Resources," Texas Workforce Solutions–Vocational Rehabilitation Services.
2. If you would like to know how Social Security benefits might be affected by earning minimum wage or above, you can contact the Ticket to Work Helpline. The number for the Ticket to Work Helpline is under the section "Local Employment Resources," Ticket to Work Helpline on page 3.
3. Besides TWS-VRS, you can also get help finding a job from an Employment Network. To find an Employment Network near you, access the website under the section "Local Employment Resources," Ticket to Work Employment Networks on page 3.
4. You can also get help finding a job in the community by contacting a local Workforce Solutions Office. To find the closest Workforce Solutions Office to you, access the website under the section "Local Employment Resources," Texas Workforce Solutions – Vocational Rehabilitation Services and Local Workforce Solutions Offices on page 3.
5. If under 15 employees, the following information has been provided:
 - ☐ Texas Self-Advocates
 - ☐ Peer-Operated Support Groups
 - ☐ Other

Required Signatures and Dates

Subminimum Wage Employee

I received Career Counseling and Information and Referral:

☐ Yes ☐ No

Individual Signature or Mark:

Date:

Subminimum Wage Guardian or Legal Representative Signature

I give my permission for Career Counseling and Information and Referral to be completed.

☐ Yes ☐ No

Guardian or Legal Representative Signature:

Date:

Date and TWS-VRS Staff Signature

Date of Career Counseling and Information and Referral:

TWS-VRS Staff Signature:

Method of Delivery

The individual received the signed document:

- ☐ In person, hand-delivered
- ☐ Mailed
- ☐ E-mailed
- ☐ Faxed

The guardian or legal representative signed and received the documents:

- ☐ In person, hand-delivered
- ☐ Mailed
- ☐ E-mailed
- ☐ Faxed

Information and Referral

Local Employment Resources

1. Texas Workforce Solutions–Vocational Rehabilitation Services and local Workforce Solutions Offices information: www.twc.state.tx.us. Telephone number: (800) 628-5115.
2. Social Security's Ticket to Work Helpline: (866) 968-7842 / (866) 833-2967 (TTY) Monday through Friday from 7:00AM–7:00PM CST.
3. Ticket to Work Employment Networks: www.choosework.net

Additional Information For 14C With Under 15 Employees

Self-Advocacy Websites:

1. Texas Project First: www.texasprojectfirst.org
2. Texas Advocates: www.texasadvocates.org

Peer-Operated Support Groups:

1. Via Hope: www.viahope.org



Texas Workforce Commission
Vocational Rehabilitation Services
**Authorization for Release of Confidential
Consumer Records and Information**

With few exceptions, you are entitled, on request, to be informed about the information that DARS releases and collects about you. You also are entitled to receive and review the information, and to have DARS correct information about you that is incorrect. (Sections 552.021, 552.023, and 559.004 of the Government Code)

Consumer's name:	Last four digits of Social Security number:	Date of birth:
------------------	---	----------------

Records or information to be released:
Demographic and employment related information only

Release information or send records to (name and address):

Texas Foundation of Hope
2845 Thousand Oaks Drive
San Antonio, Texas 78232

Purpose for disclosure (specify reason: for example, consumer request, claim, litigation, application for disability, participation in consumer appointment):

Career counseling for subminimum wage

The following considerations apply, to the extent that the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its regulations apply, to the release of any protected health information included in the information above.

Acknowledgment of notices: I acknowledge that DARS has provided me a copy of this authorization and has notified me that:

- I may refuse to sign this authorization, and my refusal to sign it will not affect my receiving services from DARS;
- any information obtained from another agency or organization may be released only by or under the conditions established by that agency or organization; and
- if DARS releases my protected health information, some or all of this information may be redisclosed. If redisclosed, this information may no longer be protected from further disclosure by law, particularly by the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Period of validity of authorization: I understand that I may revoke this release in writing at any time after signing it, except that any revocation does not affect an action taken based on this release. Until revoked by me, this release remains valid either for a period of 365 days from the date signed, or until the date when I cease to be a DARS applicant or consumer, whichever date occurs earlier.

I, on behalf of myself or any other person or entity who may have an interest in the matter, hereby release DARS, and any person or organization requesting information from DARS, from all legal responsibility and liability that might arise from this disclosure of personal information based upon this signed release.

Miscellaneous: I further authorize DARS and those disclosing my protected health care information and personal information under this authorization to exchange this information electronically (for example, by email or fax). A photocopy of this authorization is fully acceptable as an original.

Signature of consumer, parent, guardian, and/or representative: X	Printed name of consumer, parent, guardian, and/or representative: X	Date:
---	--	-------

This permission to release information complies with the Drug Abuse Prevention, Treatment and Rehabilitation Act, as amended, 42 U.S.C. Sec. 290ee-3 (290dd-2), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, 42 U.S.C. Sec. 290dd-3 (290dd-2), and 42 CFR Part 2.

... ..

[illegible]

Permission to Collect Information

Identifying data:

Consumer's name: _____

Date of birth: _____

Last four digits of Social Security number: _____

Consumer's phone number: (____) _____

Return information to:

Enter name, address, city, state, and ZIP code:

Requested information about treatment or attendance covers this time period:

From _____ through _____

Organization or Individual Authorized to Disclose

Instructions: Separate release forms must be completed for each organization or individual.

As the applicant or consumer, I authorize the provider listed below to disclose the protected health information and other personal information listed under "Information Subject to Disclosure" to the Department of Assistive and Rehabilitative Services (DARS).

Enter the name of the organization or individual:

Acknowledgment of Notice

As the applicant or consumer, I acknowledge that DARS has provided me a copy of this authorization and has notified me that:

- I may refuse to sign this authorization to allow DARS access to my protected health information and other personal information in the possession of others, and that, if I refuse to sign this authorization, I must still provide information about myself to my counselor;
- a failure to provide information may cause delay, or the termination, of DARS services to me;
- DARS requires protected health information and other personal information about me and perhaps about my family in order to develop my rehabilitation program;
- DARS may receive the protected health information from me or from others (such as health care providers whom I authorize to release this information to DARS);
- state and federal law permits DARS to collect information about me;
- my records (including alcohol and/or drug abuse information, mental status information, and human immunodeficiency virus test results) are protected by federal regulation and/or state law from disclosure; and
- DARS may redisclose or be required to redisclose some or all of this information in response to a subpoena, or to any one or more of the following: (i) medical or psychotherapeutic consultants from whom DARS purchases services to evaluate my case; (ii) community rehabilitation programs involved with my case; (iii) educational institutions in connection with my rehabilitation program; or (iv) my attorney. If redisclosed, this information may no longer be protected from further disclosure by law, particularly by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Information Subject to Disclosure

The authorized organization or individual is permitted to release to DARS the information I have initialed below (including information regulated by the HIPAA Privacy Rule and its regulations; 42 U.S.C. 290dd-2; Texas Rules of Evidence, and Texas Health and Safety Code §571.015[c]).

Initial all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Psychological evaluations and psychotherapeutic notes
<input type="checkbox"/> Alcohol and/or drug abuse treatment records
<input type="checkbox"/> Texas Department of Public Safety records
<input type="checkbox"/> Texas Department of Criminal Justice records
<input type="checkbox"/> Medical treatment records | <input type="checkbox"/> Protected health information
<input type="checkbox"/> Mental health records
<input type="checkbox"/> School records and grades
<input type="checkbox"/> Inpatient and outpatient hospitalization records
<input checked="" type="checkbox"/> Other (be specific): <u>Demographic/Employment Information</u> |
|---|--|

Purpose for disclosure: The information released by this authorization is used in connection with the applicant or consumer's rehabilitation program.

Period of validity of authorization: As the applicant or consumer, I understand that I may revoke this release in writing at any time after signing it except that any revocation does not affect an action taken based on this release. Until revoked by me, this release remains valid for either a period of 365 days from the date signed, or until the date when I cease to be a DARS applicant or consumer, whichever date occurs earlier.

Miscellaneous: As the applicant or consumer, I further authorize DARS and those disclosing my protected health care information and personal information under this authorization to exchange such information electronically (for example, email or fax). A photocopy of this authorization is fully acceptable as an original.

Applicant or Representative Signature

Signature of applicant or consumer: X	Printed name of applicant or consumer: X	Date:
Signature of parent, guardian, and/or representative (if necessary): X	Printed name of parent, guardian, and/or representative (if applicable): X	Date:
Description of representative's authority to act on behalf of the consumer:		
Signature of witness (if necessary): X	Printed name of witness (if applicable): X	Date:
Signature of DARS representative: X	Printed name of DARS representative: X	Date:

TEXAS WORKFORCE SOLUTIONS

* * * * *

Vocational Rehabilitation Services Career Counseling Workbook

Name: _____

Date: _____

Introduction

This is a career exploration workbook.

It will:

- help you think about what you like to do;
- help you learn more about careers in the community; and
- help you make decisions about work.

Part 1: What Do You Like to Do?

Here are some things you can think about while we talk about this book and what you like to do. So let's talk about:

1. Things that you like to do at home:

2. Things that you like to do at your workshop:

3. Things that you like to do in your community (around town):

4. Things you are good at doing:

5. Things that are hard for you:

6. Things that are easy for you:

Part 2: Types or Kinds of Work

There are many kinds of work you can do in the community if you want to earn at least minimum wage. So let's talk about:

On the next pages, you will see pictures of people doing different kinds of work in the community. These pictures help you think about the kinds of jobs that people do. We have asked you to think about things you like to do. Do you see the people in the pictures doing things you like to do too?



**1. Work with plants
papers**



3. Work in an office copying



**2. Work in a store hanging clothes
boxes**



4. Work in a warehouse lifting



**5. Work with animals
store**



9. Work putting groceries in the



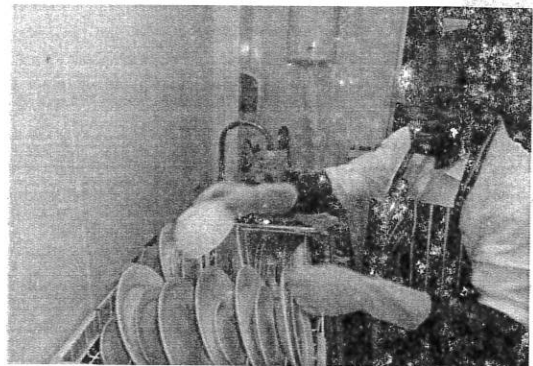
6. Work with machines



10. Work shredding paper



7. Work mowing grass



11. Work washing dishes



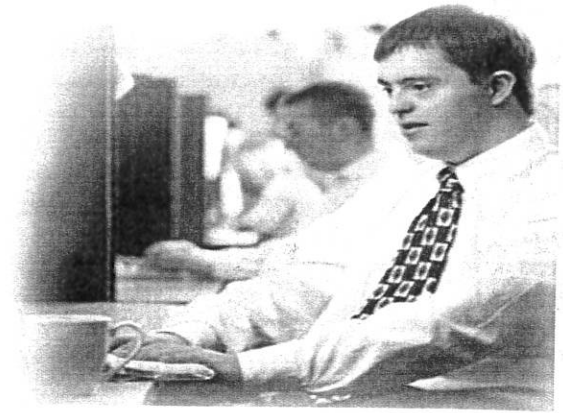
8. Work putting products on shelves



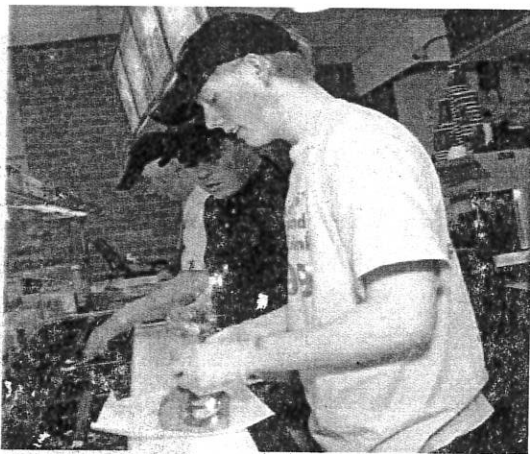
12. Work in a coffee shop



13. Work getting carts at the store computer



16. Work in an office on the computer



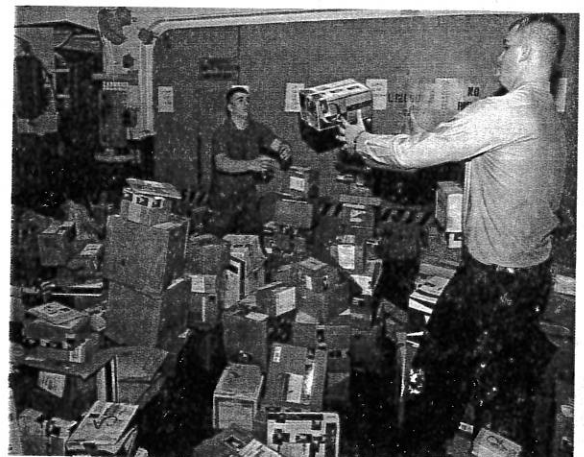
14. Work making sandwiches



17. Work in a movie theater cleaning or helping to take tickets



15. Work cleaning buildings



18. Work sorting mail



19. Work making food



20. Work cleaning tables at restaurants

Now that you have thought about things you like to do and you have looked at these pictures, we are going to ask you questions about working in the community earning at least minimum wage.

Do you think you might want to work someplace other than the workshop?

☐ Yes

☐ No

Thank you for taking time to talk with us today. We hope this book has helped you in knowing what types of jobs you might find in the community working for minimum wage.



Texas Workforce Commission
Vocational Rehabilitation Services
**Refusal to Participate in TWS-VRS
WIOA Section 511 Required
Activities**

General Instructions

This form should be completed by the TWS-VRS Point of Contact and must be provided to the individual no later than 10 days after refusal to participate.

Required Fields

Last Name:

First Name:

Middle Name:

Description of Refusal:

Reason for Refusal:

Individual's Signature:

Date:

Guardian's Signature:

Date:

TWS-VRS Signature:

Date:

This document was delivered: ☐ In person, hand-delivered
☐ Mailed
☐ Emailed
☐ Faxed

Date Sent/Delivered:

Refusal to participate in the required activities under *Workforce Innovation and Opportunity Act Section 511, Limitations on Usage of Subminimum Wage* may impact your ability to earn subminimum wage.