Admissions Interview for TRADE

Technology Related Accommodation, Development and Empowerment

The following is to be completed during the interview or returned before first class:

____ Student Agreement
____ Photo release/Info. Consent
____ Personal Information
____ Provider and Support List
____ Complaint / Grievance Procedure
____ JPSP
____ Emergency Contact Information
____ Title 17

The following optional material may be presented during the interview:

____ Business Skills Assessment
____ Data Entry Evaluation
TRADE
Student Agreement

I ________________________, agree to the following statements while I am participating in the TRADE program at EmpowerTech.

As a Student, I agree:

1. To actively participate in goal setting.
2. To provide my own transportation to and from the training site.
3. To make a conscientious effort to attend all classes and on time.
4. To inform the instructor of potential tardiness or absence.
5. To abide by Code of Participation, and set Policies.
6. To inform instructors of a change of address or telephone number.

As program providers we agree:

1. To provide an Individualized Professional Success Plan (IPSP).
2. To accommodate classes to meet the individual needs of the Student.
3. To value the Student’s feedback through the evaluation process to improve the quality of the program.

I have read and understand the above information. I also have read and understand my rights and the grievance procedures as presented in the Complaint and Grievances Procedures form.

Student Signature
(Please print Name under signature) Date

Referring Agent Signature
(Please print Name under signature) Date

Program Director
(Please print Name under signature) Date

Admin. File 1-08
EMPOWERTECH
empowering and educating people with disabilities

TRADE
Technology Related Accommodation, Development and Employability

PERSONAL INFORMATION

DATE: ____________________

Name: ____________________ S.S. #: ____________________

Address: __________________________________________
____________________________________________________
____________________________________________________

Phone Numbers: ____________________ ____________________
____________________________________________________

1. YOURSELF

- Education: (High school, Two-year college, Four-year college, Graduate school)
- Age: ____________________
- Ethnicity: ____________________
- Disability: ____________________
- Marital Status: (Single, Married, Divorced, Widowed)
- Health Status: Very good, Good, Average, Weak, Very Weak (Name of Illness:
- Family members: ____________________

2. RESIDENCE

- Who do you live with? (Spouse, Parents, Siblings, Relatives, Roommate, Alone)
- Are you planning to move soon? (Yes/No)

3. TRANSPORTATION

- How do you get around the city? ____________________
- What is your plan for transportation from your home to the ET/work?
- Do you have a transportation budget to come to ET everyday? (Yes/No)
- Can you consider getting a job anywhere in the city? (Yes/No)

Administration File Aug. 04
MEDICAL EMERGENCY DATA

Name: ________________________________

Address: ____________________________  ____________________________  __________
          STREET                                         CITY                                     ZIP

Home Phone: __________________________  Secondary Number: ________________________

Any health condition(s) that may need treatment during class or during an emergency:
________________________________________________________________________________
________________________________________________________________________________

Any medication(s) you may need during class:
________________________________________________________________________________
________________________________________________________________________________

Persons to contact in case of emergency:
________________________________________________________________________________
________________________________________________________________________________

Doctors:
________________________________________________________________________________
________________________________________________________________________________

You have my permission to take me to the hospital or call the necessary emergency medical personnel for care.

SIGNATURE: ___________________________  DATE: __________________

NOTES: _______________________________________________________
Complaint and Grievance Procedures

Formal Program Participant Grievance and Appeal Policy and Procedures

EmpowerTech provides services to people of all ages and disabilities. Services are geared toward people with disabilities, their families, and their service providers. EmpowerTech reserves the right to deny service to anyone whose behavior is disruptive to others participating in ET programs or to the staff in a way that adversely impacts the provision of service.

Rights Statement: As a participant in the programs at EmpowerTech, you have the following rights:
- To expect that the center will be accessible to you
- To be treated as the expert on your own life and abilities
- To have information provided to you so that you can make informed choices regarding services and technology

General Grievance Procedure: If a situation arises in which you as a participant in services feel you have not been treated fairly, we first suggest that you discuss the matter with the appropriate staff person. If discussion doesn't resolve the problem, or you do not feel able to bring the matter up with the staff person, you may take the following steps until a resolution is reached:

1. Report the grievance to the Executive Director within two weeks of the problem occurring. If appropriate, propose a resolution you feel would be satisfactory. The Executive Director will get back to you within 7 days to resolve the matter.

2. If the grievance is still unresolved, you may submit an appeal in writing or on audio tape to the Executive Director. Describe your complaints, what resolution you proposed and why you feel the initial proposal from the Executive Director won't work. The Executive Director will get back to you in writing within 7 days of submission of your appeal with an alternative suggested resolution.

3. If the problem remains unresolved, you may request that the grievance and all supporting documents be forwarded to the Board of Directors. The Board of Directors will have 30 days from receipt of the material to respond and take action on the grievance.

Grievance Procedures for BPPVE Participants:
From time to time, differences in the interpretation of school policies will arise among students, faculty, and/or the administration. When such differences arise, usually a miscommunication or misunderstanding is a major contributing factor. For this reason, we urge both students and staff to communicate any problems that arise directly to the individual(s) involved. If the problem cannot be resolved in this manner, contact the school administrator and/or director. The student may file a complaint if he/she is unsatisfied with the results of your inquiry Council for Private Postsecondary & Vocational Education at P.O. Box 980818, West Sacramento, Ca 95798-0818.

This Grievance Procedure will be posted in a visible place at the Training site(s).
PHOTO/MEDIA RELEASE FORM

I, __________________________, authorize EmpowerTech to photograph, video or audiotape myself and/or my children; __________________________.

(list names of child or children above)

I agree that photographs may be used for (please indicate all that apply):

______ Brochures, newsletters, web site and other promotional and fundraising materials

______ Training materials for parents and educators

______ Electronic media (television or radio)

__________________________________________  ________________________
Signature of Client or Guardian (if client under 18 years old)  Date
CONSENT TO RELEASE INFORMATION
Clients of EmpowerTech

I, ____________________________, understand that personal information/data and is confidential. I am aware that I must provide written authorization to EmpowerTech (ET) to release any of the information outlined above.

Due to the nature of EmpowerTech’s work, it is important that its staff has the ability to communicate with the public and private entities that have referred clients to EmpowerTech. This will ensure open dialogue and collaboration in the best interest of our clients.

I give EmpowerTech permission to provide information to:

_____ Regional Center – Communicate by telephone on client specific issues as necessary, release progress reports, consultations (fax, email or U.S. Mail) and other information to Service Coordinators and supervisory staff.

_____ Department of Rehabilitation – Communicate by telephone on client specific issues as necessary, release progress reports (fax, email or U.S. Mail) and other information to Rehabilitation Counselors and supervisory staff.

_____ Schools – Communicate by telephone on client specific issues as necessary, release consultation report and follow-up progress reports to appropriate school personnel as necessary.

__________________________________________  ______________________
Signature                                                                 Date

__________________________________________  ______________________
Authorized Signature (client unable to sign)                                                                 Date
STUDENT SERVICE PROVIDER LIST

NAME: ____________________________     DATE: ____________

_________________________ DEPARTMENT OF REHABILITATION
NAME: _________________________ PHONE: ( ) ____________
ADDRESS: ____________________________________________

_________________________ REGIONAL CENTER
NAME: _________________________ PHONE: ( ) ____________
ADDRESS: ____________________________________________

_________________________ ONE STOP
NAME: _________________________ PHONE: ( ) ____________
ADDRESS: ____________________________________________

_________________________ OTHER
NAME: _________________________ PHONE: ( ) ____________
ADDRESS: ____________________________________________

_________________________ OTHER
NAME: _________________________ PHONE: ( ) ____________
ADDRESS: ____________________________________________
Article 2: Rights of Persons with Developmental Disabilities

Section 50510 - Application of This Subchapter

Each person with a developmental disability, as defined by this subchapter, is entitled to the same rights, protections, and responsibilities as all other persons under the laws and Constitution of the State of California, and under the laws and the Constitution of the United States. Unless otherwise restricted by law, these rights may be exercised at will by any person with a developmental disability. These rights include, but are not limited to, the following:

(a) Access Rights.

(1) A right to treatment and habilitation services. Treatment and habilitation services shall foster the developmental potential of the person. Such services shall protect the personal liberty of the individual and shall be provided under conditions which are the least restrictive necessary to achieve the purposes of treatment.

(2) A right to dignity, privacy, and humane care.

(3) A right to participate in an appropriate program of publicly-supported education, regardless of the degree of handicap.

(4) A right to religious freedom and practice, including the right to attend services or to refuse attendance, to participate in worship or not to participate in worship.

(5) A right to prompt and appropriate medical care and treatment.

(6) A right to social interaction and participation in community activities.

(7) A right to physical exercise and recreational opportunities.

(8) A right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse or neglect. Medication shall not be used as punishment, for convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.

(9) A right to be free from hazardous procedures.
(10) A right to advocacy services, as provided by law, to protect and assert the civil, legal, and service rights to which any person with a developmental disability is entitled.

(11) A right to be free from discrimination by exclusion from participation in, or denial of the benefits of, any program or activity which receives public funds solely by reason of being a person with a developmental disability.

(12) A right of access to the courts for purposes including, but not limited to the following:

(A) To protect or assert any right to which any person with a developmental disability is entitled;

(B) To question a treatment decision affecting such rights, once the administrative remedies provided by law, if any, have been exhausted;

(C) To inquire into the terms and conditions of placement in any community care or health facility, or state hospital, by way of a writ of habeas corpus, and

(D) To contest a guardianship or conservatorship, its terms, and/or the individual or entity appointed as guardian or conservator.

(b) Personal Rights. Each person with a developmental disability who has been admitted or committed to a state hospital, community care facility, or health facility shall have rights which include, but are not limited to, the following:

(1) To keep and be allowed to spend one's own money for personal and incidental needs.

(2) To keep and wear one's own clothing.

(3) To keep and use one's own personal possessions, including toilet articles.

(4) To have access to individual storage space for one's private use.

(5) To see visitors each day.

(6) To have reasonable access to telephones, both to make and receive confidential calls, and to have calls made for one upon request.

(7) To mail and receive unopened correspondence and to have ready access to letter-writing materials, including sufficient postage in the form of United States postal stamps.

(8) To refuse electroconvulsive therapy ("ECT").

(9) To refuse behavior modification techniques which cause pain or trauma.
(10) To refuse psychosurgery. Psychosurgery means those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for any of the following purposes:

(A) Modification or control of thoughts, feelings, actions, or behavior rather than treatment of a known and diagnosed physical disease of the brain.

(B) Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.

(C) Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thought, feelings, actions, or behavior.

(11) Other rights as specified by administrative regulations of any federal, state, or local agency.

(c) Rights of State Hospital Residents. In addition to all of the other rights provided for in this subchapter, each person with a developmental disability who resides in a state hospital shall be accorded the following rights:

(1) If involuntarily detained, to have access to a current and up-to-date copy of the California Welfare and Institutions Code. This right includes the right to have assistance from the Clients' Rights Advocate in the reading and understanding of the Code.

(2) To give or withhold consent for treatments and procedures, in the absence of a judicial order or other provision of law which provides for the exercise of this right to devolve to another party.

(3) To be provided with the amount of funds specified in Welfare and Institutions Code Section 4473 for personal and incidental use if, following the initial thirty (30) days of state hospital residency, the person is not receiving an amount of income for such use which is equal to or greater than the amount authorized by Section 4473.

Authority: Section 11152, Government Code.

I acknowledge that my rights have been explained to me:

_____________________________  __________________________
Student Signature                  Date
INDIVIDUALIZED PROFESSIONAL SUCCESS PLAN (IPSP)

TIMELINE INFORMATION:
1. Start Date: ___/___/___ Stated Completion Date: ___/___/___
2. Initial IPSP Date: ___/___/___ Initial Schedule: M T W Th F
3. Meeting Dates
   • Planning Date: ___/___/___ Hours per morn/afternoon: ______
   • Mid Point Evaluation Date: ___/___/___ Modifications to Schedule:
   • Completion Date: ___/___/___

BASIC INFORMATION

Participant Name: ________________________________________________________

DOB: __________________________

Address: ____________________________________________

Telephone: (Day: __________________________) (Evening: __________________________)

Residency: _______Parent/Guardian
            _______Group Home
            _______Roommate
            _______Other: __________________________

Ethnicity:    _______Caucasian
             _______African American
             _______Hispanic American
             _______Asian American: __________________________

Primary Language: __________________________ Secondary Language: __________________________

Agency Involvement:
   _______Department of Rehabilitation: __________________________
   _______Regional Center: __________________________
   _______Public School: __________________________
   _______Workforce Investment Board/One stop/Work source Center __________________________

Community Service Organization:
   _______Parent Group: __________________________
   _______Other: __________________________

Disabilities:
   _______Specific Learning Disabilities
   _______Hard of Hearing
   _______Other Health Impaired
   _______Severely Emotionally Disturbed
   _______Deaf
   _______Autism
   _______Speech or Language Impaired
   _______Visually Impaired
   _______Developmentally Delayed
   _______Traumatic Brain Injury
   _______Orthopedically Impaired
   _______Multi-handicapped

Transportation:
   _______Drive
   _______Parent/Friend
   _______Public Transportation
   _______Other

Other Services

______________________________
______________________________
______________________________

Goals/Progress File Aug. 04
<table>
<thead>
<tr>
<th>TOPICS/CONTENTS</th>
<th>STRENGTHS</th>
<th>NEEDS</th>
<th>OTHER OBSERVATION REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Input Adaptation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Software Adaptation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Output Adaptation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MS Windows Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>File Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Backing-up Files</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MS Office Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microsoft Word</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microsoft Access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microsoft Excel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microsoft PowerPoint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internet Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using a search engine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using e-mail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest/Preference</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Goals/Progress File Aug. 04
PARTICIPANT TRAINING OBJECTIVES

1. Area of Need: Assistive Technology

   • Objective 1:

   Duration of Service: Beginning Date: ____________________ Ending Date: ____________________
   Person Responsible: __________________________________
   Evaluation Method: ___________________________________
   Result: ______ Met ______ Not Met ______ Partial (Date: ____________________)

   • Objective 2:

   Duration of Service: Beginning Date: ____________________ Ending Date: ____________________
   Person Responsible: __________________________________
   Evaluation Method: ___________________________________
   Result: ______ Met ______ Not Met ______ Partial (Date: ____________________)

   • Objective 3:

   Duration of Service: Beginning Date: ____________________ Ending Date: ____________________
   Person Responsible: __________________________________
   Evaluation Method: ___________________________________
   Result: ______ Met ______ Not Met ______ Partial (Date: ____________________)

2. Area of Need: Computer Skills

   • Objective 1:

   Duration of Service: Beginning Date: ____________________ Ending Date: ____________________
   Person Responsible: __________________________________
   Evaluation Method: ___________________________________
   Result: ______ Met ______ Not Met ______ Partial (Date: ____________________)

   • Objective 2:

   Duration of Service: Beginning Date: ____________________ Ending Date: ____________________
   Person Responsible: __________________________________
   Evaluation Method: ___________________________________
   Result: ______ Met ______ Not Met ______ Partial (Date: ____________________)

   • Objective 3:

   Duration of Service: Beginning Date: ____________________ Ending Date: ____________________
   Person Responsible: __________________________________
   Evaluation Method: ___________________________________
   Result: ______ Met ______ Not Met ______ Partial (Date: ____________________)
PARTICIPANT TRAINING OBJECTIVES

SIGNATURE PAGE

The following were participants in the development of this Individualized Professional Success Plan:

Participant

Program Director or Representative

Instructor I

Instructor II

Instructor III

Organization Representative I

Organization Representative II

Organization Representative III