

APPLICATION—Project SEARCH

ProMedica Charles & Virginia Hickman Hospital



Today's Date: _____

COMPLETE AND RETURN TO:

Glen Bowman, Project SEARCH Classroom
ProMedica Charles & Virginia Hickman Hospital
5640 N. Adrian Hwy., Adrian, MI 49221 OR

glen.bowman@lisd.us Application Due Date: **February 24, 2023**

Student Information

Name	_____	DOB	_____
Street Adr.	_____	School District	_____
City, Zip	_____	IEP Case Manager	_____
Cell Phone	_____		_____
Email	_____		_____

Parent / Guardian Information

	Father	Mother
Name		
Home Phone		
Cell Phone		
Place of Employment		
Work Phone		
Email		

Legal Guardian Information

Are you 18 years old and your own legal guardian? Yes No

***If no, please attach a copy of guardianship court documents.

Educational Needs and Goals (Student's High School)

Are you working towards your High School Diploma? Yes No

Are you working towards your High School Certificate of Completion? Yes No

Anticipated date to finish school services: _____

How many days did you miss from school last year? _____

Have you ever been suspended or expelled while in high school? If yes, please describe. Yes No

Other than public education, have you received any additional formal training? Yes No

If yes, list experiences, date, and location of any additional formal training.

School Work Based Learning

Please list your Work Based Learning experiences below.

	Organization 1	Organization 2	Organization 3
Organization			
Duties			
Hours/Week			
Supervisor			
Phone #			
Dates of Service			

Employment Needs and Goals

What are your employment goals? Full-time (40 hrs/wk) Part-time (20 hrs/wk)

What type of work would you like to do (i.e., landscaping, cleaning, retail work, etc.)?

Do you have previous paid work experience OUTSIDE of the school programming? Yes No

If yes, provide the details requested below.

	Employer 1	Employer 2
Employer		
Job Title		
Hours/Week		
Supervisor		
Phone #		
Dates of Employment		

Have you received job coaching or other support in previous jobs? Yes No

If yes, who was the job coach?

Did you receive any disability accommodations in previous jobs? If yes, please describe. Yes No

If you have had any previous jobs, were you able to get the job without assistance? Yes No

Have you ever been fired from a job/job experience? If yes, why? Yes No

Have you ever quit a job? If yes, why? Yes No

Criminal History

Have you ever been convicted of a felony or misdemeanor? Yes No
 If so, please explain the circumstances:

Have you ever been accused of stealing or any other crime? Yes No
 What are the circumstances?

Volunteer Experience

Do you have previous volunteer experience? Yes No
 If so, provide the details requested below.

	Organization 1	Organization 2
Organization		
Volunteer Duties		
Hours/Week		
Supervisor		
Phone #		
Dates of Service		

Community Support Services

Do you receive services from the following community agencies?

Agency	Receiving Services?	Case Manager Name and Phone Number
Community Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Michigan Rehabilitation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Department of Human Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Level of Independence and Supports Needed

Are you able to independently maintain a household budget? Yes No

Whom do you currently live with? _____

Are there plans for this living arrangement to change during the next year? Yes No

What are your long-term living plans?

Do you currently hold a Driver's License? Yes No

Do you plan to obtain a Driver's License within the next year? Yes No

Can a family member provide you transportation to ProMedica Charles & Virginia Hickman Hospital? If so, who? Yes No

Can you travel to ProMedica Charles & Virginia Hickman Hospital using public transportation? In the future, what transportation will you use to get to employment? Yes No

Do you set and use an alarm clock? Yes No
 Do you get up in the morning on your own? If not, who wakes you up in the morning? Yes No

Do you sometimes need help with bathing, grooming and dressing? Yes No
 If yes, please check one: Minimal Assistance Occasional Assistance Total Assistance

Do you need assistance at home? Yes No
 Do you need assistance at school? Yes No
 Who assists you? _____
 What assistance do you need? _____

Medical History

Do you have any medical conditions? _____

Please list any hospitalizations and/or surgeries you have had:

Date	Hospital	Reason

Do you have allergies? Yes No
 If yes, what? Medical Seasonal Food Environmental
 Please provide additional information: _____

Do you take medication on a regular basis? Yes No
 If so, provide the details requested below.

Medication Taken on a Regular Basis

Medication	
Purpose	
Dosage Amount	
Dosage Schedule	
Prescribing Physician	
Physician's Phone #	

Does your school have an Emergency Medical Plan for your medical condition? Yes No
If yes, please attach.

Do you wear glasses or contacts? Yes No

Do you use any devices or aids to assist with your hearing? Yes No
If so, explain the nature of your hearing impairment:

Do you use sign language or any other nontraditional form of communication? Yes No
Do your parents/guardians/family members use sign language or any other nontraditional form of communication? Yes No

Socialization

Please list some past experience with school teams, clubs or groups.

Who assisted you with this application? _____

Signature _____ Date: _____



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