School to Work Project Application

Personal Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Contact Phone number: _____ Date of Birth: _____

DDD Case Manager Name: _____

High School: _____ Teacher: _____

Open case with DVR: (circle one) Yes NO DVR Worker: _____

Emergency Contact Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Primary Phone: ( ) _____ Alternate Phone: ( ) _____

Relationship: _____

What are your employment goals?

What job experience do you have?

What have you done to find a job so far?

What are your likes and dislikes?

What are your skills and abilities?

Signature **Date**

Guardian Signature (if applicable) **Date**

Please return this application to:

Spokane County DD Program
Attn: Denise Magee
312 W. 8th Ave.
Spokane, WA 99204

Department of Social & Health Services

CONSENT

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- ☒ Developmental Disabilities @ Spokane County Community Services
- ☐ Mental health care providers: _____
- ☐ Chemical dependency service providers: _____
- ☒ Other DSHS contracted providers: Developmental Disabilities Administration (DDA)
- ☐ Housing programs: _____
- ☒ School districts or colleges: _____
- ☐ Department of Corrections: _____
- ☐ Employment Security Department and its employment partners: _____
- ☐ Social Security Administration or other federal agency: _____
- ☒ See attached list Department of Vocational Rehabilitation (DVR)
- ☒ Other: County Contracted Employment Agencies

I authorize and consent to sharing the following records and information (check all that apply):

- ☐ All my client records
- ☐ Records on attached list
- ☐ Only the following records
  - ☐ Family, social and employment history
  - ☐ Payment records
  - ☐ Other (list):
  - ☐ Health care information
  - ☐ Individual assessments
  - ☐ Treatment or care plans
  - ☐ School, education, and training

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Chemical Dependency (CD) services

- **This consent is valid for ☐ one year ☐ as long as DSHS needs records, or ☐ until _____ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.