Supported Employment Cover Sheet for DORS Application

Individual's Name: _____*

Date of Birth: _____*

☐ Individual has Medical Assistance/Medicaid, OR

☐ Individual does not have Medical Assistance; however, he/she meets uninsured eligibility requirements

Primary Diagnosis*
(Please select as diagnosed by the treating licensed clinician):

Primary Diagnosis

May include other specifiers WITH THE EXCEPTION OF "single episode," in "partial remission," or "in full remission." Also, may co-occur with an intellectual disability or neurodevelopmental disorder, i.e., communication disorder, autism spectrum disorder attention deficit/hyperactivity disorder, motor disorder or other neurodevelopmental disorder provided that the co-occurring diagnosis does not meet eligibility criteria for Developmental Disability Administration services and the most prominent symptoms, behavior, or functional impairments are primarily attributable to a diagnosed serious mental illness and NOT primarily attributable to an intellectual disability or neurodevelopmental disorder.

Additional Diagnoses*:

_____

_____

_____

The information contained in this document has been verified and is true to the best of my knowledge and I possess the required licensure to make this determination.

*Clinician Signature	*Credentials	*Title/Organization	*Date

For Individuals Age 26+: Functional Limitations*
(Please select all that apply)

☐ Demonstrates inability to maintain independent employment, characterized by an established pattern of unemployment, underemployment, or sporadic employment, which requires intervention by the behavioral health system beyond what is typically available in mainstream workforce development or social service organizations, and which is primarily associated with a diagnosed serious mental illness and NOT primarily associated with an intellectual disability or neurodevelopmental disorder;

AND two or more of the following functional limitations:

☐ Social behavior that results in interventions by the behavioral health system

☐ Inability, due to cognitive disorganization, to procure financial assistance to support living in the community

☐ Severe inability to establish or maintain a personal support system

☐ Need for assistance with basic living skills

For Individuals 16-25: Functional Limitations*
(Please select all that apply)

☐ Demonstrates marked inability to negotiate the developmental tasks of emerging adulthood and to assume normative adult roles, characterized by a pattern of disruption in the developmentally appropriate exploration of opportunities for employment, school, and social relationships, which requires intervention by the behavioral health system in facilitating life course decisions beyond what is typically required by youth and young adults in general; AND

☐ Demonstrates marked inability to function in a work or school setting due to absent or impaired psychological, emotional, social or cognitive skill development which is primarily attributable to symptoms, behavior or other functional limitations primarily associated with a diagnosed mental illness and NOT primarily associated with an intellectual disability or neurodevelopmental disorder;

AND one or more of the following functional limitations:

☐ Need for frequent assistance with performing developmentally appropriate self-care tasks or maintaining one's personal environment

☐ Marked impairment in impulse control, emotional regulation, or judgment

☐ Persistent inability to effectively manage the symptoms of one's illness

☐ Persistent inability to modulate one's behavior, not otherwise manifested by criminal behavior, in response to social cues and societal or cultural norms

☐ Marked or persistent inability to independently initiate and complete tasks or to sustain effort and perseverance

☐ Marked impairments in reality testing or social behavior associated with psychosis

Does the individual express the desire to work in competitive, integrated employment?* ☐ Yes ☐ No

I have attached the following documents to this cover sheet:

1. A completed DORS Application
2. Documentation of disability signed by a licensed clinician

I understand that if it is determined at a later date that my organization received supported employment funding for the above identified individual from the Division of Rehabilitation Services (DORS) or the Behavioral Health Administration (BHA), that we are not eligible for, we may be required to reimburse the associated State agency for the funds received. By signing below, I attest that the information submitted is true and correct to the best of my knowledge.

*Staff Signature	*Title/Organization	*Date