**MVLE, Inc.**
7420 Fullerton Road, #110, Springfield Virginia 22153
Tel: (703) 569-3900; Fax: (703) 569-3932

# APPLICATION FOR EMPLOYMENT AND SUPPORT SERVICES

| **Applicants please include: *Most current* psychological evaluation, vocational evaluation, current resume, and if applicable, current IEP and behavior intervention plan** | |
|---|---|
| **Name:** | **Date:** |
| **Address:** | **Residential Contact (*if other than applicant*):** |
| | **Tel. #:** |
| **Person Completing Application:** | **Signature:** |
| **Date of Initial Contact:** | **Referral Source:** |
| **Reason for Applying:** | |
| | |
| **Funding Source/Eligibility (Check all that apply):**<br>☐ Fairfax/Falls Church CSB ☐ Alexandria CSB<br>☐ Arlington CSB ☐ Fairfax DARS ☐ Alexandria DARS<br>☐ ID Waiver ☐ DD Waiver | **LTESS (Long Term Employment Support Services) Funding available/requested?:**<br>☐ Yes<br>☐ No |
| **Type of employment desired:** ☐ Full-time employment ☐ Part-time employment ☐ Day Support | |
| **Support Services desired (check all that apply):** ☐ Nursing support ☐ Behavioral support ☐ Physical Therapy<br>☐ Speech Therapy ☐ Life skills training ☐ Pre-employment/transition training ☐ Community Outings<br>☐ Volunteer opportunities ☐ Other recreational/therapeutic activities | |
| **Primary diagnosis:** | |
| | |
| | |
| **Secondary diagnosis**: | |
| | |
| | |
| **Chronic Medical Conditions:** | |
| | |
| | |
| | |

| **Other needs not listed above (*i.e., mental health, physical, communication, hearing, visual, sensory, dietary*):** |
|---|
| |
| |
| |

**EDUCATION/VOCATIONAL TRAINING HISTORY**
**(*List most recent first*)**

| Education/Training Program Name and Address | Program | Start Date | End Date |
|---|---|---|---|
| | | | |
| | | | |

**EMPLOYMENT HISTORY**
**(*List most recent first*)**

| Employer Name and Address | Position/Duties | Start Date | End Date |
|---|---|---|---|
| | | | |
| Reason(s) for leaving: (Please be specific. Include any issues while on this job). | | | |
| Employer Name and Address | Position/Duties | Start Date | End Date |
| | | | |
| Reason(s) for leaving: (Please be specific. Include any issues while on this job). | | | |
| Employer Name and Address | Position/Duties | Start Date | End Date |
| | | | |
| Reason(s) for leaving: (Please be specific. Include any issues while on this job). | | | |

| **INTERESTS, TALENTS, HOBBIES, AND GOALS** |
|---|
| |
| |

**Signature of Applicant:** **Date:**

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# Employee Profile

**Updated On:** **Transportation Info:**

| **IDENTIFYING INFORMATION** | | | |
|---|---|---|---|
| Full Name: | Date of Birth: | Admission date: | |
| Address: (number and street) | Telephone #: | Email: | |
| City, State, Zip Code | Point of Contact: | | |
| Guardianship status: ☐ Own ☐ Has guardian<br>***Please provide copy of guardianship document*** | P.O.C. Telephone # (if different): | | |
| Social Security Number: | Medicaid Number (if applicable): | Marital Status: | |

| **PARENT/LEGAL GUARDIAN INFORMATION** | |
|---|---|
| Name(s): | Relationship: |
| Address: | Telephone # (W): |
| | Telephone # (H): |

| **EMERGENCY CONTACTS** | |
|---|---|
| List below person who MUST be contacted, in the order of contact. If parent/guardian, enter below in proper order. | |
| Name(s): | Relationship: |
| Address: | Telephone # (W): |
| | Telephone # (H): |
| Name(s): | Relationship: |
| Address: | Telephone # (W): |
| | Telephone # (H): |
| Name(s): | Relationship: |
| Address: | Telephone # (W): |
| | Telephone # (H): |

| **MEDICAL INSURANCE INFORMATION** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Medical Insurance Company: | | | | | POLICY #: | | |
| | MEDICAID | | MEDICARE | | CHAMPUS | | ID#: |

| **EMERGENCY MEDICAL AUTHORIZATION** | |
|---|---|
| **Purpose**: to facilitate emergency treatment should the individual become ill or injured at work, en-route to the job site or when participating in an activity organized and/or authorized by the agency. | |
| Preferred Hospital: | |
| Address: | Telephone #: |
| | Alternative Telephone #: |
| Preferred Physician: | |
| Address: | Telephone #: |
| | Alternative Telephone #: |
| Preferred Dentist: | |
| Address: | Telephone #: |
| | Alternative Telephone #: |

1. In the event that, in the judgment of MVLE/employer staff, emergency medical treatment is necessary, I hereby give my consent for the transfer to the above hospital, or other reasonably accessible hospital.
2. In the event that the above designated practitioner(s) is/are not available, I hereby give my consent for the utilization of emergency medical personnel.

Note: This authorization does not cover major surgery unless the opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery. Such opinions must be obtained prior to the performance of such surgery.

| | |
|---|---|
| Employee's Signature: | Date: |
| Legal Guardian Signature: | Date: |

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| MVLE Staff Signature: | Date: |
|---|---|

| **CURRENT MEDICAL INFORMATION** | | | | |
|---|---|---|---|---|
| Date of Current Physical: (please attach a copy) | | Date of Current TB Test: | | |
| Allergies (PAST & CURRENT): | | | | |
| | | | | |
| Substance Abuse: | | | | |
| | | | | |
| | | | | |
| | | | | |
| **MEDICATION/DRUGS (including prescription, non-prescription, nicotine, and alcohol):** | | | | |
| Medication/Drug | Dosage | Frequency/Time | Purpose | Start/End Date |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| SIGNIFICANT MEDICAL CONDITIONS/PROBLEMS: (IE: Sight/hearing/speech, seizures, arthritis, diabetes, phobias, communicable diseases – Please mark all that apply) | | | | |
| ☐ Diabetes ☐ Seizures ☐ Vision ☐ Hearing ☐ Arthritis ☐ Falls Risk ☐ Paralysis | | | | |
| ☐ Dietary (Please indicate type): _____ | | | | |
| ☐ Cerebral Palsy ☐ Cancer ☐ Asthma ☐ COPD ☐ ☐ Colostomy Care ☐ Ostomy Care | | | | |
| ☐ Heart Disease ☐ Thyroid Disease | | | | |
| ☐ Other: (Please indicate): _____ | | | | |
| Past Serious Illnesses, Injuries and Hospitalizations: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Does the individual have an Advanced Directive (DNR)? ☐ Yes ☐ No** | | | | |
| ***If yes original medical documentation must be filed with the MVLE nursing office***. | | | | |

MVLE Staff signature confirms that all the information is accurate as reported by the individual, parent/guardian, or case manager. The Employee Profile form is to be reviewed during each annual evaluation to ensure the information is current and appropriate. Changes are to be completed on another Employee Profile form. A MVLE staff and individual or guardian's dated signature will confirm a renewal of the individual profile form without changes.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| MVLE Staff Signature | Employee Signature | Date |
| _____ | _____ | _____ |
| MVLE Staff Signature | Employee Signature | Date |
| _____ | _____ | _____ |
| MVLE Staff Signature | Employee Signature | Date |

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# *MVLE Vocational Functional Analysis Survey*

This survey has been adapted from the "Level of Functioning Survey" that has been provided by DMAS. Please complete to the best of your ability.

*Name of Person Surveyed:* _____

**Definition of Terms:**

- "Never" means that the behavior does not occur.
- "Rarely" means that the behavior occurs quarterly or less.
- "Sometimes" means that the behavior occurs once a month or less.
- "Often" means that the behavior occurs 2-3 times a month.
- "Regularly" means that the behavior occurs weekly or more.

**1. Health Status: How often is care or supervision by a licensed nurse or person certified in medication administration required for the following?** (Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Medication administration and/or evaluation for effectiveness of a medication regimen. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Direct services such as care for lesions, dressings, and treatments (not including shampoos, foot powder, etc.) | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Seizure control and/or monitoring | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Teaching diagnosed disease and diet control/care, including diabetes | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Management of care of diagnosed circulatory or respiratory problems | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Motor disabilities which interfere with all activities of daily living such as dressing, mobility, toileting, etc. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Observation for choking or aspiration while eating, drinking | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Supervision of use of adaptive equipment, i.e. special spoons, braces, etc | 1 | 2 | 3 | 4 | 5 |
| Observation for nutritional problems (i.e. undernourishment, swallowing difficulties, obesity) | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Has a diagnosis of a chronic disease and has been in an institution for 20 years or more | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

**2. Communication** (Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Indicate wants by pointing, vocal noises, facial expressions or signs | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Use simple words, phrases, short sentences with or without the use of communication device | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Ask for at least 10 things using appropriate names with or without the use of a communication device | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Understand simple words, phrases or instructions containing prepositions such as on, in, or behind. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Communicate in an easily understood manner | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

Identify self, place or residence and significant others with or without the use of a communication device ..... 1☐ ..... 2☐ ..... 3☐ ..... 4☐ ..... 5☐

Respond to auditory stimuli (may use hearing aid)..... 1☐ ..... 2☐ ..... 3☐ ..... 4☐ ..... 5☐

**3. Task Learning Skills: How often does this individual perform the following activities?** (Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Pay attention to purposeful activities for 5 minutes. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Stay with a 3-step task for more than 15 minutes. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Tell time to the hour and understand time intervals. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Count more than 10 objects. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Do simple addition, subtractions. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Write or print 10 words. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Discriminate shapes, sizes or colors | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Name people or objects when describing pictures | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Discriminate between “one”, “many” and “few” | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

**4. Personal/Self Care: Can this individual, without assistance, currently perform the following tasks?** (Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Perform toileting functions: i.e. maintain bladder and bowel continence, clean self, etc | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Perform eating/feeding functions: i.e. drink liquids and eat with a spoon or fork, etc | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Perform bathing functions: i.e. washes hands after performing eating/toileting | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Dress upon entering/exiting building. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Dress self completely after performing toileting, i.e. including fastening and putting on clothes | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

**5. Mobility: Can this individual, without assistance, currently perform the following tasks?** (Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Move (walking, wheeling) around environment | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Stand to a sitting position | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Sit without support | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Use one or both arms to independently carry a large object. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Use either hand to pick up a small object | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Walk up and down stairs with rails | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Walk up and down curbs | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

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**6. Behavior: How often does this individual perform the following behaviors?** (Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Engage in self-destructive behavior | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Threaten or do physical violence to others | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Throw things, damage property, have temper, outbursts | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Respond to others in a socially unacceptable manner without undue anger, frustration or hostility.. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

**7. Community Living Skills: Can this individual, without assistance, currently perform the following activities?**
(Please check one number for each statement)

| | Never | Rarely | Sometimes | Often | Regularly |
|---|---|---|---|---|---|
| Prepare lunch at mealtime | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Take care of personal belongings | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Add coins of various denominations up to one dollar | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Use the telephone to call home, doctor, fire, police.. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Recognize survival signs/words: i.e. stop and go traffic lights, police, men or women restrooms, danger, etc.. | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Refrain from exhibiting unacceptable social behavior in public | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Safety navigate in offsite, community-based, multi-level settings (elevators, escalators) | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |
| Make minor purchases, i.e. candy, soft drink, etc | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ |

**Person Completing Evaluation:**

_____ _____
**Name (Please Print)** **Relationship to Individual**

_____ _____
**Signature** **Date (Month/Day/Year)**

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# LEARNING STYLE PROFILE

| Name: | Medicaid #: | Report Date: |
|---|---|---|
| Completed by (*please include title, agency*): | | Signature: |

**<u>Directions</u>: Please comment on all of the following topics using the guidelines provided in the parentheses. You may use the reverse side should you require more space.**

COMMUNICATION *(Types of communication or combination of these which enable the learner to learn a new task in the most efficient manner: physical (proprioceptive, kinaesthetic, tactile (hand-over-hand, use of jigs), visual (sign language, gestures, pictures/symbols, modelling/demonstration), auditory (verbal) -- level of understanding of basic concepts/directions)*

ENVIRONMENTAL CONDITIONS *(Optimal staff ratio, peer grouping, room size, temperature, noise level, lighting, etc...)*

REINFORCERS / MOTIVATORS *(Optimal reinforcement frequency and type - e.g., food, music, praise, money, points, quotas, self-motivation, etc...)*

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INDIVIDUAL APPROACH TO TASK *(Response to new stimuli (attention level, fear, acclimation rate), attention to task (new and old), distractions, processing of information, motivation, dependence on supervision, prompts, and rewards, amount of practice necessary before spontaneity of task, degree of spontaneity, problem solving skills, etc...)*

RETENTION AND GENERALIZATION *(application of skill to new situation, recall over time, frequency of review for maintenance, etc.)*

OBSTACLES TO PROGRESS *(interfering behaviours, medical problems, personal/social adjustment, physical impairments, use of adaptive equipment, etc.)*

SELF-ADVOCACY: *(Check all that apply)*

- ☐ Requests assistance when needed
- ☐ Expresses needs
- ☐ Identifies disability in functional terms
- ☐ Appropriately assertive – internalises frustrations
- ☐ Accesses resources
- ☐ Other (describe)

COMMUNITY ACCESS: *(Check all that apply)*

- ☐ Drives
- ☐ Uses public transportation with support
- ☐ Uses recreational facilities
- ☐ Uses community resources with support
- ☐ Other (describe)

WORKER CHARACTERISTICS: *(Check all that apply)*

| | | |
|---|---|---|
| ☐ Dependable | ☐ Accurate | ☐ Communicates appropriately |
| ☐ Motivated to work | ☐ Demonstrates appropriate speed | ☐ High quality of work |
| ☐ Persistent | ☐ Adaptable to change | ☐ Maintains stamina |
| ☐ Independent worker | ☐ Appropriate problem solving skills | ☐ Exhibits self-awareness |

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# Behavior Intake Questionnaire

In order to better assist MVLE staff in developing an appropriate support plan to meet this individual's needs, it is critical to have complete and up-to-date information as part of our intake process. This includes a full description of the individual's behavioral repertoire, both past and present. The questionnaire below may be completed individually or collaboratively by those involved in the person's daily habilitation.

**Applicant's Name _____ D.O.B. _____**

**Referral Source _____ Primary Diagnosis _____**

**Date of Report _____ Medical Condition(s) _____**

**Reporter's Name _____ Reporter's Signature _____**

**Relationship to Applicant _____**

**Length of Time Providing Service/Care (# months, years) _____**

**Applicant's Behavioral Challenges** (please indicate the frequency, severity of the behavior by answering the following:

1. Has the individual **ever** demonstrated **aggression toward others? No**☐ **Yes**☐

2. If **"Yes," when** was the **last incident? Date at: home_____ school_____ work_____ other_____**

   **a. Toward** (check all that apply): **staff**☐ **peers**☐ **family members**☐ **others (i.e., in the community)**☐

3. Please describe **how aggressive behavior** is **typically performed** in **observable** terms (i.e., hits with an open palm, pinches, pulls hair, etc.):

_____
_____
_____

   **a. Average frequency** (i.e., # times/day/week/month): _____

   **b. Average intensity** (i.e., mild=no injury moderate=causes bruising/abrasion high=causes open wounds/broken bones): _____

4. Has the individual **ever** demonstrated **self-injurious behavior?: No**☐ **Yes**☐

   **a.** If **"Yes," when** was the **last incident? Date at: home_____ school_____ work_____ other_____**

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**5.** Please describe **how self-injurious behavior** is **typically performed** in **observable** terms (i.e., bangs head on walls/objects, picks at skin, hits side of face with closed fist, etc.):

_____
_____
_____

**a. Average frequency** (i.e., # times/day/week/month): _____

**b. Average intensity** (i.e., mild=no injury moderate=causes bruising/abrasion high=causes open wounds/broken bones): _____

**6.** Has the individual ever demonstrated any **other disruptive, interfering or dangerous behaviors?:**
**No**☐ **Yes**☐

**a.** If **"Yes," when** was the **last incident? Date at: home_____ school_____ work_____ other_____**

**7.** Please describe any **other disruptive, interfering or dangerous behaviors** that the individual demonstrates or has demonstrated in the past (i.e., elopement, property destruction, opposition, tantrum) in **observable** terms:

_____
_____
_____

**a. Average frequency** (i.e., # times/day/week/month): _____

**b. Average intensity** (i.e., mild=minimal disruption/no damage moderate=temporarily disrupts immediate environment/reparable damage high=major disruption/irreparable damage):
_____

**8.** Do the behaviors (i.e., property destruction, aggression, self-injurious behavior, etc.) typically occur in a predictable **sequence** or **cluster**? If so, please explain:

_____
_____

**9. When** do(es) the behavior(s) usually occur? [State specific antecedent(s) for each behavior noted above (i.e., self-injurious behavior follows the presentation of an instructional demand, tantrum follows denied access to a desired item/activity, etc.)].

_____
_____

**10.** What is the **most effective** method to **interrupt** or **redirect** the behavior(s) to **a positive alternative?**

_____
_____

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## 11. Other Pertinent Observations/Comments

_____
_____
_____

**Targeted Job Site** _____

**Supports Needed** (i.e., staffing patterns/ratios, environmental modifications, assistive technology, etc.)

_____
_____
_____