

**Send completed form to Carrie.Louque@EmploymentSource.org, along with your [State Participation Form](#).*



Employment Source
A ServiceSource Affiliate

Works for Me

Pre-ETS Consumer Data Information Sheet

1. Date:
2. Name:
3. DOB:
4. Gender:
5. Race:
6. School:
7. Address:
8. Allergies:
9. Guardian's Name:
10. Guardian's Cell phone:
11. Guardian's Email:
12. Primary Disability:



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Informed Consent Agreement For Service Delivery

Student Name: _____

Student Date of Birth: ____/____/____

Name of Parent/Legal Guardian: _____

PROGRAM: After clear explanation of program structure, rules, benefits, potential risks, and possible alternate methods, I (we) give consents for _____ (student's name) to receive **Pre-Employment Transition Services** from ServiceSource. I (we) understand that this service is voluntary and that this consent may be withdrawn with written notification at any time.

INTERVENTIONS: In the case of an emergency where the staff member has exhausted verbal de-escalation techniques (MANDT) and a consumer is still being physically aggressive, a threat to self or others, or is destroying property, the staff member will call 911 and request intervention by law enforcement. Physical restraints, devices and Isolation Time-outs will not be used.

AMENDMENTS: I (we) understand that this document may be amended on an "as needed" basis, and that any such amendment will require the signature of the consumer or, if legally declared incompetent or being a minor, the legal guardian.

ACCEPTANCE: I (we) have read and/or have been clearly explained the terms, conditions and agreements of this informed consent agreement and voluntarily accept them as stated or amended as specified below. This agreement may be withdrawn at any time but will not exceed one year after the date signed.

Expiration Date of Informed Consent for Service Delivery: _____

(Not to exceed one year)

Student Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____

Name: _____

INFORMED CONSUMER CHOICE

This form is to be completed upon referral/intake and annually for continued service to document informed consumer choice.

Student Name: _____

I _____ (consumer/parent/guardian) acknowledge that I/we have been provided information on the benefits of receiving Pre-Employment Transition Services (Pre-ETS) training through the *Works for Me* program sponsored by Employment Source.

Please check one of the following:

_____ I choose to receive support services from Employment Source.

_____ I choose *NOT* to receive Pre-ETS services from Employment Source

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Revised: June 18, 2024



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EMERGENCY CONTACTS RELEASE

Permission for emergency care

Employment Source has permission in an emergency to take _____ (student's name) to the emergency room of a hospital for the purpose of receiving emergency medical and/or surgical treatment that may be deemed necessary by the emergency room physician.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

EMERGENCY CONTACTS

First Contact (please print)

Name: _____ Home Phone: _____

Relationship: _____ Work Phone: _____

Street: _____ Cell Phone: _____

City/State: _____

Second Contact (please print)

Name: _____ Home Phone: _____

Relationship: _____ Work Phone: _____

Street: _____ Cell Phone: _____

City/State: _____

Name:



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TRANSPORTATION RELEASE

Employment Source is a vocational training center dedicated to preparing adults with disabilities for competitive employment. Our staff members frequently transport individuals for job development and on-the-job training.

By signing below, you hereby grant permission to allow Employment Source staff to transport you for job development and on-the-job training.

We appreciate your support and cooperation. Please remember that transportation is only provided temporarily, and the individual, guardian, or caregiver is responsible for coordinating transportation after the individual is placed in competitive employment.

Student's Name: _____ Date: _____

Student's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Employment Source Staff: _____ Date: _____

Releases expire 1 year from date of signature.



Student: _____

Legal Guardian/Authorized Representative (if applicable): _____

I, (*above named participant*), hereby authorize Employment Source, its employees or agents to take photographs, video or audio recordings of me and allow any images, video or audio taken of me to be used both publicly and privately for:

- Printed material (Including, but not limited to annual reports, brochures, advertisements, fact sheets/flyers, signage, presentations, event materials)
- Employment Source public website(s) or websites of partner organization for the purposes of promoting Employment Source programs.
- Other electronic material (including, but not limited to the Employment Source website, e-newsletters and social media outlets such as Facebook, Instagram, Twitter, LinkedIn, and YouTube)
- Promotional displays or videos

Or Other Specific Purpose:

Anticipated Duration of Use: For the life of the publication.

I further consent that my name and information about my place of employment may be revealed by descriptive text or commentary _____ (*initial*)

I understand that my photograph/video will be used in a dignified and discreet manner. I further understand that the resulting publicity will enhance opportunities for people with disabilities through promotion of the mission of Employment Source.

This authorization may be revoked by myself or my legal guardian/authorized representative (if applicable) at any time, through request to the contact/address shown below.

Signature of Student

Date

Parent/Guardian/Authorized
Representative (if not program participant named above)

Date

Witness

Date

Employment Source
Communications Department
communications@servicesource.org



Employment Source

A ServiceSource Affiliate

600 Ames Street
 Fayetteville, NC 28301
 Direct Line: 910-826-4699
 Fax: 910-485-4341

AUTHORIZATION TO RELEASE INFORMATION

Student's Name: Date of Birth:	Last 4 of Social Security Number:
Name/Address of agency, organization or individual which possesses information to be released:	Name/Address of agency, organization or to whom information is to be release Employment Source, Inc Attention: Carrie Louque 600 Ames St. Fayetteville, NC 28301 Cell: 910-699-3621 Fax: 910-485-4341
Information requested (Specify the nature and extent of information to be released) For program qualification one of the following is required: IEP including BIP (if applicable) <i>or</i> 504 Plan <i>or</i> Medical Information Related to Disability Or Guardianship papers All information that is being provided should pertain to the documented disability.	Purpose(s) or need for which the information is to be used for Works for Me (Pre-Employment Transition Services Program) qualification All documentation of disability is kept in a confidential setting. This information is required by our funding sources so that we may provide Employment & Training Services to our program participants.
<p>I hereby request and authorize the above-named agency, organization or individual which possesses information relative to the individual named above to release information, as specified, to the agency, organization or individual named on this request. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, sickle cell anemia, or psychological or psychiatric information. I also understand that the information may be released and/or disclosed verbally, electronically, faxed, and/or photocopied.</p> <p>I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by state or federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire: 1 yr. upon satisfaction of the need for disclosure: within <u>365</u> days from the date signed; not to exceed one (1) year.</p>	
_____ Student Signature Date: _____	_____ Parent/Guardian Signature Date: _____
*Signature of Witness _____ Date _____	
(* ONLY WHEN INDIVIDUAL MAKES A MARK (X) PERSON WITNESSING MUST SIGN.)	