



INDIVIDUAL EMPLOYMENT PLAN & ASSESSMENT

Today's Date: _____

Full Legal Name (First, Middle, Last): _____

Primary Phone #: _____ Secondary Phone #: _____

E-mail Address: _____

What is the best way to contact you? Email Primary Phone Secondary Phone

Gender: Male Female Transgender MTF Transgender FTM Gender Neutral

Other: _____

Preferred Pronouns: _____

Date of Birth: ____/____/____ Social Security: ____ - ____ - ____

Are you a U.S. Citizen? Yes No

Are you an immigrant, refugee, or new arrival to this country? Yes No Unknown

Are you limited in your ability to communicate in English? Yes No Unknown

Are you eligible to work in the US? Yes No

Have you ever served on active duty in the U.S. military including National Guard or Reserves? Yes No

If yes, Active Dates: _____ Branch of the Military: _____

Theaters of Operations: _____ Honorable Discharge: Yes No

Race (Check all that apply):

American Indian or Alaska Native Asian, Asian American White or Caucasian Hispanic/Latino

Native Hawaiian or Pacific Islander Black, African-American, Other African Other Race: _____



HOUSING

Are you currently homeless (living on the streets, in a car, RV, or a structure without utilities)? Yes No

What is the **zip code** where you live or stayed last night? _____

How many **times** have you been homeless on the streets, stayed at an emergency shelter, or stayed at a Safe Haven in the last 3 years? _____

What are the total number of **months** you have been homeless on the streets, at an emergency shelter, or a Safe Haven in the last 3 years? _____

Your Current Housing Type:

- | | |
|--|---|
| <input type="checkbox"/> Street | <input type="checkbox"/> Fleeing domestic violence and facing homelessness |
| <input type="checkbox"/> Shelter, specify: _____ | <input type="checkbox"/> Transitional Housing, specify: _____ |
| <input type="checkbox"/> Treatment Facility, specify: _____ | <input type="checkbox"/> Jail, prison, or juvenile detention facility |
| <input type="checkbox"/> Permanent housing for formerly homeless | <input type="checkbox"/> In a vehicle, specify type: _____ |
| <input type="checkbox"/> Relative's place permanently | <input type="checkbox"/> Temp living with family (need to move within 14 days) |
| <input type="checkbox"/> Friend's place permanently | <input type="checkbox"/> Temp living with friends (need to move within 14 days) |
| <input type="checkbox"/> Rent without subsidy | <input type="checkbox"/> Subsidized rent |
| <input type="checkbox"/> Own without subsidy | <input type="checkbox"/> Subsidized own |

Your Address: _____

City: _____ State: _____ Zip Code: _____

How long have you stayed at your current housing status? _____

How long have you lived in Washington State? _____ Where did you live before that? _____

What is your household composition?

- | | |
|--|--|
| <input type="checkbox"/> Single-parent female household w/minors | <input type="checkbox"/> Single-parent male household w/minors |
| <input type="checkbox"/> Single minor | <input type="checkbox"/> Single adult |
| <input type="checkbox"/> Two-parent household w/ minors | <input type="checkbox"/> Other related adults w/minors |
| <input type="checkbox"/> Other related adults | <input type="checkbox"/> Unknown |



HEALTH

Do you consider yourself to be a person with disabilities? Yes No Unknown

If yes, please describe: _____

Do you receive services from DDA/DVR? Yes No Unknown

If yes, please describe services and list Case Manager: _____

Have you ever had a problem with drugs or alcohol? Yes No If so, which types? _____

Have you used drugs or alcohol in the past 30 days? Yes No

If yes, please describe: _____ If no, how long have you been clean and sober? _____

Have you ever been enrolled in a treatment program for drugs or alcohol? Yes No

If yes, where and when did you receive treatment for drugs and/or alcohol? _____

Have you ever been diagnosed with depression or mental illness? Yes No

If yes, please describe: _____

Have you received treatment for depression or mental illness? Yes No

If yes, please describe: _____

Have you taken medication for depression or mental illness? Yes No

If yes, please describe: _____

List any medications you are currently taking: _____

Do you have any food or other allergies? _____

List any other significant past and present medical/mental health conditions/disabilities that may influence your ability

to work in the food service industry or be in training: _____



EDUCATION

Did you graduate from high school? Yes No If no, the highest grade completed: _____

If no, did you receive a GED? Yes No

Do you have any additional education or training? Yes No

Program: _____ Year completed: _____

Additional Education/Training Level:

Some college AA or equivalent Bachelor's Degree

Graduate School Vocational/Technical school Other: _____

Do you have a history of difficulty in school or a diagnosed learning disability? Yes No

If yes, please describe: _____



EMPLOYMENT (INDIVIDUAL EMPLOYMENT PLAN)

Have you been employed in the food service industry? Yes No

If yes, explain: _____

Have you worked in the last 12 months? Yes No

If yes, how long did you work (in months)? _____ If no, what year did you last work? _____

Hourly Wage: _____ Hours per week: _____ Employer: _____

Do you understand that working may change your government benefits? Yes No

List any barriers you have experienced (check all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Frequent Relocation | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Child Health Issues |
| <input type="checkbox"/> Lack of Basic Resources | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Child w/Special Needs | <input type="checkbox"/> Housing Issues |
| <input type="checkbox"/> Lack of Job History | <input type="checkbox"/> Lack of Child Care | <input type="checkbox"/> Owing Child Support | <input type="checkbox"/> Criminal History |
| <input type="checkbox"/> Conflict w/supervisor | <input type="checkbox"/> Lack of Credit or Bad Credit | <input type="checkbox"/> Physical Health | <input type="checkbox"/> Skill Deficiency |
| <input type="checkbox"/> Lack of Financial Literacy | <input type="checkbox"/> Domestic/Family Violence | <input type="checkbox"/> Lacking Diploma/GED | <input type="checkbox"/> Lacking Life Skills |
| <input type="checkbox"/> Lacking ID/SS Card | <input type="checkbox"/> Transportation | <input type="checkbox"/> Veteran Discharge Status | |
| <input type="checkbox"/> Termination of Public Assistance | | <input type="checkbox"/> End of Relationship/Divorce | |
| <input type="checkbox"/> Other: _____ | | | |



**DEPARTMENT OF SOCIAL & HEALTH SERVICES
CONSENT/RELEASE OF INFORMATION**

I, _____, permit the Washington State Department Social and Health Services and Columbia Ability Alliance Opportunity Kitchen to use and share confidential information about me (except as limited below) as necessary for Employment and Training (E&T) activities as required by the Basic Food E&T (BFET) program.

This consent is valid for a maximum of three years from the date signed unless I withdraw or change my consent in writing.

This consent DOES NOT permit the sharing of sensitive information about my mental health, chemical dependency, HIV/AIDS and STD test results, diagnosis, or treatment.

I understand that I must fill out a separately approved consent form if I am under 18 years of age, I want to limit further information shared about me, someone else is representing me in this matter, or I want to allow sharing of sensitive information about my mental health, chemical dependency, HIV/AIDS and STD test results, diagnosis, or treatment.

Client Signature

Date

Agency Contact/Witness Signature

Date



LEGAL

Do you have any warrants, court dates, or other upcoming legal issues? Yes No

If yes, please explain, and include dates and locations if applicable. *Continue on back if necessary.*

Have you ever been convicted of a misdemeanor? Yes No

If yes, please list convictions, dates, and locations. *Continue on back if necessary.*

Have you ever been convicted of a felony? Yes No

If yes, please list convictions, dates, and locations. *Continue on back if necessary.*

Are you on probation? Yes No

Are you in work release? Yes No

Contact and phone number for work release: _____

CCO/DOC Name: _____ Phone Number: _____

BACKGROUND CHECK RELEASE

For Columbia Ability Alliance to be able to assist our students in achieving self-sufficiency we must be aware of any barriers to success our applicants face. We ask that all applicants consent to a criminal history search to aid in this process.

By initialing below, I agree to allow Columbia Ability Alliance to conduct a criminal history search. **I understand that failure to disclose criminal convictions can be grounds for denial of enrollment.**

_____ Initials



FINANCIAL & SUPPORTIVE SERVICES

Are you currently receiving income from any of the following sources?

- Do you have a pending SSI or SSDI Application? Yes No
- Social Security (including SSI and SSDI): Yes No Amount: \$ _____
- Aging, Blind, Disabled benefit (ABD): Yes No Amount: \$ _____
- Housing and Essential Needs (HEN): Yes No Amount: \$ _____
- Basic Food Benefits: Yes No Amount: \$ _____
- Temporary Aid to Needy Families (TANF): Yes No Amount: \$ _____
- Veteran's Benefits: Yes No Amount: \$ _____
- Other: Specify: _____ Yes No Amount: \$ _____
- Employment Income: Yes No Amount: \$ _____
- Unemployment Benefits: Yes No Amount: \$ _____
- Child Support: Yes No Amount: \$ _____
- Are you a non-custodial parent and paying child support? Yes No Amount: \$ _____

Do you have health insurance coverage?

- Medicaid (Apple Health) Medicare Veteran's Health Care
- COBRA Employer-Provided Insurance Private Pay Health Insurance
- Indian Health Insurance Program No Health Insurance Other: _____

Are you involved with any of the following agencies or programs?

- Basic Food & Employment Training (BFET) Division of Vocational Rehabilitation (DVR)
- Workforce Investment Act (WIA) WorkFirst
- Neighborhood House Other: _____



OPPORTUNITY KITCHEN STUDENT HOURS

Once enrolled, your training schedule will vary based on what phase you are in. The schedule for the entire 12 weeks is as follows:

Phase 1 (weeks 1-4) Monday through Friday 8:30 AM to 3:00 PM

Phase 2 (weeks 5-8) Monday through Friday 8:30 AM to 3:00 PM

Phase 3 (weeks 9-12) Monday through Friday 8:30 AM to 3:00 PM

I understand that the above schedule indicates the times that I am required to be available to participate in this program.

_____ **Initials**

In 3 to 5 sentences, please tell us what brings you to Columbia Ability Alliance and your goals for employment:

How did you find out about the Opportunity Kitchen Program? Please be as specific as possible:

- | | |
|---|-----------------|
| <input type="checkbox"/> Opportunity Kitchen Student or Graduate | Name: _____ |
| <input type="checkbox"/> Media | Type: _____ |
| <input type="checkbox"/> Columbia Ability Alliance Outreach Event | Name: _____ |
| <input type="checkbox"/> Probation Officer | Location: _____ |
| <input type="checkbox"/> Drop-In Center / Community Center | Name: _____ |
| <input type="checkbox"/> Shelter | Name: _____ |
| <input type="checkbox"/> DSHS | Location: _____ |
| <input type="checkbox"/> Treatment Center | Name: _____ |
| <input type="checkbox"/> Family or Friends | |
| <input type="checkbox"/> Other | List: _____ |

Have you ever applied to / volunteered for Columbia Industries before? Yes No If yes, what year? _____

Are you willing to sign a **Release of Information Form** for Columbia Ability Alliance Opportunity Kitchen to work with your doctor, counselor, parole/probation officer and/or other service providers? Yes No



OPPORTUNITY KITCHEN PROGRAM REQUIREMENTS

Listed below are some of the Opportunity Kitchen Program Requirements: *(Please initial after each requirement)*

I understand that **daily attendance** is required. _____

I understand that I must be **on time and prepared to stay the entire day.** _____

I understand that **100% participation** is expected. _____

I understand that I must be willing to **accept instruction** from my instructors and supervisors and complete the work that is assigned to me with a **positive attitude.** _____

I understand that I must have a **willingness to confront my personal challenges and/or barriers to successful employment and self-sufficiency.** _____

I understand that I must be **clean and sober.** _____

I understand that I **may not use Columbia Ability Alliance as an address** for any purpose. (mail, packages, deliveries, etc.) _____

I understand that I will be provided with a **locker and a combination lock** for my use while I am enrolled in the Opportunity Kitchen program. _____

I understand that **Columbia Ability Alliance's Opportunity Kitchen is not responsible for the damage, loss, or theft** of any of my personal property. _____

I understand that **Columbia Ability Alliance's Opportunity Kitchen is an employment training program.** _____

By participating, I'm committed to gaining employability skills and actively participating in job search. _____

I certify that the information provided is true to the best of my knowledge. I am also aware that the information I have provided is subject to review and verification and I may have to provide documentation to support this form. I allow the release of this information for verification purposes and understand that it will be used to determine eligibility. I understand that receiving services is subject to the availability of government funds.

Intentional false statements may result in termination from the Opportunity Kitchen Program at Columbia Ability Alliance.

Applicant's Signature: _____ Date: _____

Staff Signature: _____ Date: _____