DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 ● APPLE VALLEY, CA 92307
(760) 242-6333 ● (760) 242-5363/6339 FAX

Transition Partnership Program
Referral Form

Directions to Teacher:

Please make sure all the information is completed and submitted to Kaori Hartzler at the Desert/Mountain SELPA with a copy of the student's last complete IEP (with goals and Transition Plan) and his or her last complete psycho-educational evaluation. **Incomplete referrals will be returned to the TPP Teacher indicated**. Please keep a copy for your records.

Prior to the student working, the Desert/Mountain SELPA Transition Case Technician will collect all documents required for employment including a copy of the student's social security card and a picture ID. Having copies of these documents available would be greatly appreciated.

Required Information

Student Name: _____

Disability: _____

Your Name (Teacher): _____

IEP Case Manager (if not you): _____

School Site: _____

District: _____

Date submitted to the D/M SELPA with IEP and psycho-educational evaluation: _____

Desert/Mountain SELPA
17800 Highway 18 • Apple Valley, CA 92307 • (760) 242-6333, ext. 148
Contact: Adrienne Shepherd

Department of Rehabilitation
15415 W. Sand Street, 2nd Floor • Victorville, CA 92392 • (760) 245-5960

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Transition Partnership Program
Student Application Information Sheet

PERSONAL INFORMATION

Student Name: _____

Date of Birth: _____ Grade: _____ Social Security No.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Other Phone: _____

JOBS I MIGHT LIKE TO DO OR PLACES I MIGHT LIKE TO WORK ***WHILE IN HIGH SCHOOL***

(1) _____ (2) _____

JOBS I MIGHT LIKE TO DO OR PLACES I MIGHT LIKE TO WORK ***AFTER I GRADUATE***

(1) _____ (2) _____

JOBS I WOULD ***NOT*** LIKE TO DO OR PLACES I WOULD ***NOT*** LIKE TO WORK

(1) _____ (2) _____

(3) _____ (4) _____

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Transition Partnership Program Referral
Parent Letter

Date: _____

Dear Parent/Guardian,

Congratulations! _____ has been selected to participate in the Transition Partnership Program. As a partnership with the Department of Rehabilitation, the Desert/Mountain Special Education Local Plan Area (SELPA), and local school districts, this program provides wonderful pre-employment and employment services for students. Students with exceptional needs are supported in our community as they move from school into the adult world.

Prior to placement, students participate in a job-readiness class at their school site, including how to find, keep and leave a job. The Department of Rehabilitation conducts an intake interview with parents and students to assist in developing a plan for employment. As students become ready, the Desert/Mountain SELPA provides job search assistance, job coaching and a job club when needed.

If your son/daughter has your permission to participate in this program, please complete, sign and return the enclosed forms.

If you have any questions or concerns, please feel free to contact me at _____

Sincerely,

TPP Teacher

ENCLOSURES

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 ● APPLE VALLEY, CA 92307
(760) 242-6333 ● (760) 242-5363/6339 FAX

Transition Partnership Program
Parent/Student Permission Slip/Release

Dear Parent/Guardian:

If your son/daughter has your permission to participate in the Transition Partnership Program (TPP), please complete, sign, and date the consent below.

Student Name: _____ **Social Security No.:** _____

I hereby give consent for my son/daughter to participate in the Transition Partnership Program and in part-time employment. I will give support for my student to maintain good work habits ☐ Yes ☐ No

I hereby give my consent to the County Superintendent of Schools to take, or authorize others to take still pictures, motion pictures, videotapes, or voice recordings. I understand that these may be used for educational, public interest, or informational purposes through the media, radio, television, newspaper, or firm (not required for participation) ☐ Yes ☐ No

I hereby consent to and authorize the Desert/Mountain SELPA to:

1. Obtain from you or the district in which your student attends all psychological, medical, educational, vocational assessment, IEP, and any other pertinent records. ☐ Yes ☐ No
2. Release to the Department of Rehabilitation or the district in which your student attends all psychological, medical, educational, vocational assessment, any other pertinent records. ☐ Yes ☐ No
3. Are you a client of Inland Regional Center (IRC)? If yes, please provide the name of the Case Worker. ☐ Yes ☐ No
   Case Worker: _____
4. Permission to contact and communicate with Inland Regional Center (IRC) Case Worker. ☐ Yes ☐ No
5. Are you eligible to receive Medi-Cal services? If yes, please provide Medi-Cal#: _____ ☐ Yes ☐ No
6. Permission to verify dates of employment. ☐ Yes ☐ No

AS PART OF THE TRANSITION PARTNERSHIP PROGRAM (TPP), "PAID WORK EXPERIENCE" HOURS MAY BE AUTHORIZED FOR SENIORS FOR JOB TRAINING.

THIS CONSENT FORM IS SUBJECT TO REVOCATION AT ANY TIME AND WILL EXPIRE THREE YEARS FROM THE DATE OF SIGNATURE OR JUNE 30, 2015 (WHICHEVER DATE COMES FIRST)

PLEASE SIGN BELOW TO INDICATE THAT YOU UNDERSTAND THAT IT IS <u>YOUR</u> RESPONSIBILITY TO:

1. Keep an accurate timesheet (processing of my first paycheck will take a minimum of 4 weeks).
2. Have my timesheet completed and signed no later than the 20th of each month (in order to avoid a delayed paycheck).
3. Keep track of my hours and not work more than the number of hours authorized (I will not be paid for any hours I work in addition to the authorized hours).

Signed By: _____ Date: _____
Parent/Guardian (only if student is under 18)

Signed By: _____ Date _____
Student

Rev. 03/13

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 ● APPLE VALLEY, CA 92307
(760) 242-6333 ● (760) 242-5363/6339 FAX

Notice to Students

Important Steps for Successfully Getting a Job through TPP or WorkAbility	
Step 1	Meet with Transition Case Technician to complete payroll paperwork, discuss employment opportunities and barriers.
Step 2	Transition Case Technician locates a job site based on the student's needs and abilities.
Step 3	Transition Case Technician schedules first interview with employer. If for any reason the student needs to reschedule, it is the responsibility of the student to call the employer and reschedule.
Step 4	Student attends scheduled interview with employer. Please remember to dress in interview attire. You only have one chance to make a first impression. This is a real job and could lead to a permanent position.
Step 5	After the student has interviewed, the student must notify the Transition Case Technician immediately.
Step 6	After the student has phoned, the Transition Case Technician will then call the employer to see how the interview went. It is up to the employer to accept or deny the student. If the student is accepted, the Transition Case Technician and employer will determine a start date and time.
Step 7	Once the student is accepted and a start date is determined, the Transition Case Technician will complete the paperwork process and create a timesheet for the student.
Step 8	The Transition Case Technician will deliver the timesheet to the employer and notify the student and employer to begin training.

Reminders to All Students

Only after the Transition Case Technician has notified you may you start work. If you arrive at your job site and there is no timesheet, call your Transition Case Technician immediately. Do not start working without a timesheet. It is the student's responsibility not to work more than your approved number of hours. Your Transition Case Technician will hand write your approved hours on the top of your timesheet. If at any time you have a question about how many hours you have left, call your Transition Case Technician. If you forget to sign your timesheet, it will not be processed during that pay period; therefore, you will not be paid until the following payday. Timesheets are picked up around the 20th of every month and you will receive your paycheck on the 9th of the next month. If for some reason you do not receive your check, call your Transition Case Technician.

Reminder to All Students *Under Age 18*

Every student under the age of 18 who is not a high school graduate or who has not completed their G.E.D. must obtain a work permit. This gives you permission to work as a minor. Each time you change jobs and the start of a new school year, you will need to obtain a new work permit.

Steps for Obtaining a Work Permit (*Students under Age 18 Only*)	
Step 1	Obtain the work permit application from your school and take it home for your parent and/or legal guardian to sign and fill out the top portion.
Step 2	Take the work permit application to the job site interview and have the employer fill out employer section and sign.
Step 3	Return work permit application to your school and they will type up an original, which you will sign. You will receive a white work permit.
Step 4	You must make sure that your Transition Case Technician receives a copy of your work permit. Once you have obtained the work permit, call your Transition Case Technician.
Step 5	Take the work permit with you when you report to work for the first time. The employer must keep your work permit on file for their protection.

MY SIGNATURE BELOW MEANS THAT I UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

Student Signature	Date	Parent/Guardian Signature	Date

STATE OF CALIFORNIA — DEPARTMENT OF REHABILITATION

CONSENT TO RELEASE MEDICAL INFORMATION

DR 264A (REGS/Rev. 11/04)

See Page 3 for Important Notices

Individual/Facility Name & Address:	Consumer Full Name:	
Desert Mountain SELPA 17800 Highway 18 Apple Valley, CA 92307	Consumer Address:	
Name/Title of Person/Firm: Transition Case Technician/DM SELPA	Social Security Number:	Date of Birth:
Nature of Treatment: / Date Last Treated:	Other Identifying Name:	Clinic or P.F. #:

CONSENT TO OBTAIN MEDICAL INFORMATION:

I authorize the above listed individual/facility to furnish to the Department of Rehabilitation (DOR) my records containing medical history, treatment, and diagnosed mental and physical condition, including disabilities such as drug, alcohol, and psychiatric, or the result of any HIV test performed. This information will be included in my case record and used to assist in the determination of eligibility and, if eligible, subsequent vocational rehabilitation services. The DOR may not disclose the information received without my signed consent for each disclosure unless the disclosure is specifically required or permitted by law. This consent shall remain valid for 30 days unless otherwise specified in Box A below.

Particularly requested is information from <u>onset</u> to <u>present</u> regarding my current general health status, including specific information pertaining to:

(if applicable) Psycho-Educational evaluations, 504 documentation, school nurse documentation, Orthopedic evaluations, and other current medical documentation.

My signature below verifies that I have read the notifications on page 3 of this form and have received a copy of these notifications.

I understand that I have the right to receive a copy of this signed authorization.

Consumer Signature: (If minor or using "mark", see Box B and/or C) ✍		Date Signed:
Box A - Specified date, if other than 30 days: June 30th, 2015	**Consumer Signature:** ✍	Date Signed:
Box B - Parent or Guardian Signature (required for minor): ✍		Date Signed:
Box C - If unable to write his/her name, the consumer should enter an "X" or other mark above. Signatures of two (2) witnesses are required.	Witness Signature: ✍	Date Signed:
	Witness Signature: ✍	Date Signed:

Send Information To: Department of Rehabilitation 15415 W. Sand Street Victorville, CA 92395	Rehabilitation Counselor:
	Telephone: Check if TTY: ☐

DISTRIBUTION: Original - Addressee Copy - Case Record Copy - Consumer

Consumer Full Name:

CONSENT TO RELEASE MEDICAL INFORMATION:

I authorize the Department of Rehabilitation to release medical/dental/allied health information from my case record as shown below. This information may not be further disclosed without my signed consent. This consent shall remain valid for 30 days unless otherwise specified in Box A below.

Release Information to (Name & Address of Individual or Facility)**:**

Desert Mountain SELPA
17800 Highway 18
Apple Valley, CA 92307

Information to be released is limited to:

(if applicable) Psycho-Educational evaluations, 504 documentation, school nurse documentation, Orthopedic evaluations, and other current medical documentation.

My signature below verifies that I have read the notifications on page 3 of this form and have received a copy of these notifications.

I understand that I have the right to receive a copy of this signed authorization.

Consumer Signature: (If minor or using "mark", see Box B and/or C) ✍		Date Signed:
Box A - Specified date, if other than 30 days: June 30, 2015	**Consumer Signature:** ✍	Date Signed:
Box B - Parent or Guardian Signature (required for minor): ✍		Date Signed:
Box C - If unable to write his/her name, the consumer should enter an "X" or other mark above. Signatures of two (2) witnesses are required.	Witness Signature: ✍	Date Signed:
	Witness Signature: ✍	Date Signed:
Information Released By: Department of Rehabilitation 15415 W. Sand Street Victorville, CA 92395	Rehabilitation Counselor:	
	Telephone:	Check if TTY: ☐

DISTRIBUTION: Original - Addressee Copy - Case Record Copy - Consumer

NOTIFICATION TO CONSUMER

A consumer may refuse to allow the Department of Rehabilitation (DOR) to obtain medical information and may line out any form language and initial the change. If medical information is not obtained to substantiate a disability, it may result in a finding of ineligibility for services.
If the consumer wishes to disallow the DOR to release specific medical information contained in the consumer's file to outside entities, s/he may refuse to sign the release.

NOTIFICATION OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

You have the right to revoke this authorization by providing written notice to your Rehabilitation Counselor or the local office serving you. If you revoke the authorization it will not affect information already used or released before we received your written notice.

The federal Health Insurance Portability and Accountability law (HIPAA) may not protect information after it is released or provided to agencies not covered by that law. Even though the DOR does not fall under HIPAA legislation, the DOR does adhere to federal and state confidentiality requirements.

NOTIFICATION OF THE INFORMATION PRACTICES ACT OF 1977

This is confidential information from the records of the DOR. State and federal law and departmental regulations prohibit you from making any further disclosure of this information without the informed written consent of the person to whom this information pertains. Under State law and departmental regulations, all information that you supply to the DOR is maintained in the consumer's file and is subject to inspection by the enclosed named individual and other authorized person(s) and agencies.

PRIVACY STATEMENT

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (5 USC 552a(e)(3)) require this notice to be provided to individuals when collecting personal information. The information requested on this form, including the Social Security Number, is necessary to properly identify the individual to ensure that the DOR provides services to the correct individual. Failure to provide the information requested may result in delays in services. Department authority: Welfare & Institutions Code Sec. 19005, 19005.1, 19010.

STATEMENT OF NONDISCRIMINATION

The DOR affirmatively supports all federal and state civil rights laws and will not knowingly do business with any agency or entity which discriminates on the basis of ethnic group identification, national origin, race, color, creed, religion, sex, age, sexual orientation, physical or mental disability, medical condition, marital status or ancestry.

STATE OF CALIFORNIA
CONSENT TO RELEASE NON-MEDICAL PERSONAL/CONFIDENTIAL INFORMATION
DR 264 (REGS/Rev. 01/90)

DEPARTMENT OF REHABILITATION

See Reverse for Important Notices
De favor de leer el otro lado de esta pagina

To	Applicant/Client's Full Name (Print)	
Desert Mountain SELPA		
Address	Social Security Number	Date of Birth
17800 Highway 18 Apple Valley, CA 92307	Address	
Name/Title of Person/Firm	Other Identifying Name	Other Identifying Number
Transition Case Technician/DM SELPA		

I hereby consent to and authorize the Department of Rehabilitation to:
☒ obtain from you the following information:
☒ release to you the following information:

Description of information to be released:

(if applicable) Individual Educational Evaluation (IEP), other school documentation, information pertaining to conversations with SELPA or DOR staff, work release information, and other work related items as necessary.

I understand that I have the right to receive a copy of this signed authorization

I understand that this consent shall be valid for a period not to exceed 30 days, unless otherwise specified*, from the date this consent is signed.

*Specified date, if other than 30 days.
June 30th, 2015

(Stamp, print or type)
From / ☒ Send Information to:

Department of Rehabilitation
15414 W. Sand Street
Victorville, CA 92395

Applicant/Client's Signature ✍ | Date

Parent or Guardian's Signature (required for minor) ✍

If unable to write his/her name, the applicant/client should enter an "X" or other mark, signatures of two witnesses are required.

Witnesses' Signature ✍

Telephone	Rehabilitation Counselor	Witnesses' Signature ✍

DISTRIBUTION: Copy 1 (Original) - Addressee Copy 2 - Case File Copy 3 - Applicant/Client

NOTIFICATION OF THE INFORMATION PRACTICES ACT OF 1977

If information is being OBTAINED from you, you should be aware that under State law and departmental regulations, all information you supply to the Department of Rehabilitation is maintained in files that are subject to inspection by the applicant/client.

If information is being RELEASED to you, you should be aware that this is confidential information from the records of the California Department of Rehabilitation. State law and departmental regulations prohibit you from making any further disclosure of this information without informed, written consent of the person to whom this information pertains.

AVISO DEL LAS REGLAS TOCANTE EL ACTO DE 1977 DE INFORMACION

Si usted va a DAR información, debe de saber que esta es información confidencial contenida dentro de los archivos del Departamento de Rehabilitación estatal. Leyes estatales y regulaciones departamentales le prohiben a usted hacer cualquier otra revelación de esta información sin el concentimiento informado y escrito de la persona de quien pertenece esta información.

Cuando usted nos entrega informacion debe de saber que bajo la leyes estatales y regulaciones departamentales, toda la información que usted le de al Departamento de Rehabilitacion se mantiene en archivos que pueden ser inspeccionados por el solicitante/cliente.

STATEMENT OF NONDISCRIMINATION

The Department of Rehabilitation affirmatively supports all federal and state civil rights laws and will not knowingly do business with any agency or entity which discriminates on the basis of ethnic group identification, national origin, race, color, creed, religion, sex, age, sexual orientation, physical or mental disability, medical condition, marital status or ancestry.

DECLARACION CONTRA LA DISCRIMINATION

El Departamento de Rehabilitación declara que está de acuerdo con las leyes federales y estatales y no establecerá negocios con agencias o organizaciónes si se da cuenta que la discriminación existe contra personas por razon de su grupo etnico, raza, color, origen nacional, religion, sexo, credo, edad, orientación sexual, incapacidad física o mental, condición medica, estado civil o ascendencia.

SUPPLEMENTAL PERSONAL INFORMATION

DR 222A (Rev. 2/12)

Name:	Gender: ☐ Male ☐ Female
Email Address:	TTY

1. Race and Ethnicity Checklist (optional)
   - ☐ American Indian or Alaskan Native
   - ☐ Asian Group: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander Group: ☐ Guamanian or Chamorro ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
   - ☐ White
   - ☐ Hispanic or Latino
   - ☐ Other_____
2. What is your primary language?
3. What is your current living arrangement?
   - ☐ Private Residence
   - ☐ Adult Correctional Facility
   - ☐ Community Residential/Group Home
   - ☐ Halfway House
   - ☐ Homeless Shelter
   - ☐ Mental Health Facility
   - ☐ Nursing Home
   - ☐ Rehabilitation Facility
   - ☐ Substance Abuse Treatment Center
   - ☐ Other: _____
4. Are you registered to vote? ☐ Yes ☐ No
5. How many people are in your family?
6. What is your marital status?
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Separated
   - ☐ Never Married
7. What is your family monthly income (gross income)? $ per month
8. What is your primary source of support?
   - ☐ Friends/Family
   - ☐ Own Income
   - ☐ Public Support (please complete the following):
     - $ _____ Supplemental Security Income (SSI) ☐ Aged ☐ Blind ☐ Disabled ☐ Applied ☐ Denied ☐ Pending ☐ Discontinued/Terminated
     - $ _____ Social Security Disability Insurance (SSDI) ☐ Based On Disability ☐ Other ☐ Applied ☐ Denied ☐ Pending ☐ Discontinued/Terminated
     - $ _____ Veteran's Administration (VA)
     - $ _____ Temporary Aid to Needy Families (TANF)
     - $ _____ General Assistance (GA)
     - $ _____ Worker's Compensation (WC)
     - $ _____ Other Public Assistance

9. What type of medical insurance do you have?

- ☐ Medicare
- ☐ Medicaid (Medi-Cal)
- ☐ Private (employment)
- ☐ Private (other)
- ☐ Worker's Compensation
- ☐ None

10. What is the highest level of education you have achieved?

- ☐ No formal schooling
- ☐ Elementary (1-8 grade)
- ☐ Secondary (no HS diploma)
- ☐ Special Education
- ☐ HS graduate/ equivalency certificate
- ☐ Post-secondary, no degree
- ☐ AA/AS degree
- ☐ Vocational Tech certificate
- ☐ Bachelor's degree
- ☐ Master's degree or higher

11. Check if you are or have been involved in the following educational programs:

- ☐ Individualized Education Program
- ☐ Transition Program Participant

12. What was the last year you were employed?

13. What is your current work status?

- ☐ Employed (with support)
- ☐ Employed (without support)
- ☐ Extended Employment
- ☐ Homemaker
- ☐ Not Employed: All other students
- ☐ Not Employed: Other
- ☐ Not Employed: Student/secondary education
- ☐ Not Employed: Trainee/Intern/Volunteer
- ☐ Self Employed (not BEP)
- ☐ State Agency Business Enterprises (BEP)
- ☐ Unpaid Family Worker

14. If you are working, how many hours do you work per week?

15. How much do you earn? $ per (hour, week, month)

16. Please check any program(s) in which you have participated/are participating:

- ☐ Veteran
- ☐ Migrant or Seasonal Farm Worker
- ☐ Projects with Industry

17. What do you need from the Department of Rehabilitation to gain or maintain employment?

18. What are your employment needs?

19. Other comments: