Preferred Name: _____

Info Session Date: _____

Culinary Job Training Program Eligibility Criteria:

1. Be at least 18 years of age
2. Be physically able to work using hands, standing and moving doing various tasks unassisted for both 7+ hours per day and can lift up to 50 pounds
3. Be motivated to learn, dependable and have excellent attendance
4. Be legally authorized to work in the United States
5. Must want a job or career in Food Service
6. Be in class from 8:00 a.m. to 3:30 p.m. Monday through Friday
7. Be willing to undergo a criminal background check and address the effects associated with employment.
    a. ***Note:*** The presence of most conviction(s) may not exclude you from participation.

On your Orientation day, please submit the following documents:

- A government issued picture identification: (driver's license or state identification card or passport)
- Copy of your legal work eligibility, such as a social security card, work permit, etc.

GENERAL INFORMATION

First:_____Middle:_____ Last _____

Preferred Pronoun (*check one*): she/her ☐ he/his ☐ they ☐ ze ☐

SSN:_____ _____ _____ Age: _____ DOB __ __ ____Gender: _____

Current Address: _____
Street City State Zip

Telephone: H_____Cell_____Message_____

Preferred Contact: Home ☐ or Cell ☐ E-mail:_____

(Optional): Veteran: **Yes** ☐ **No** ☐ and Race/Ethnicity_____

Employment Eligibility:

Do you have a Driver's License or State ID**?** **Yes** ☐ **No** ☐

Do you have a Birth Certificate? **Yes** ☐ **No** ☐

Do you have a Social Security card? **Yes** ☐ **No** ☐

Are you legally entitled to work in the United States? **Yes** ☐ **No** ☐

Referral Information:

Do you currently have a friend/relative in Work Options program? **Yes** ☐ **No** ☐

Have you participated in the Work Options program before? **Yes** ☐ **No** ☐

How did you hear about the training program (*check one*)?

Pamphlet/ Flyer ☐ Tabling/ Job Fair ☐ Word of Mouth (family,friend) ☐

Website ☐ Denver TANF* ☐ Other County TANF* ☐

Parole/Probation* ☐ Employment First* ☐ Other Agency* ☐

List:_____

*If TANF, SNAP or Other Agency, list caseworker name:_____

HOUSING

Current Living Situation *(check one):*

☐ Shelter/Street/Inconsistent/Experiencing Homelessness (Specify:_____)

☐ Staying with a friend or relative

☐ Transitional housing (Specify:_____)

☐ Halfway house (Specify:_____)

☐ Residential treatment program (Specify:_____)

☐ Rent (Specify Monthly Rent:_____)

☐ Own

How many days can you stay at current location (*check one*)?

30 days or less ☐ 30-60 days ☐ 60-90 days ☐ 90+ days ☐

Behind on rent/mortgage? **Yes** ☐ **No** ☐ **If yes,** how much? _____

TRANSPORTATION

Current method reliable transportation: bus ☐ car ☐ bike ☐ walk ☐ friend ☐

Are you currently receiving transportation assistance? **Yes** ☐ **No** ☐

If yes, Agency Name: _____

FAMILY/CHILDREN

Marital Status: Single ☐ Divorced ☐ Married ☐ Civil Union ☐ Widowed ☐ Other ☐

Currently providing care or shelter for any person over 18 who is unable to care for themselves?

Yes ☐ **No** ☐ **If yes**: Elderly ☐ Person w/disability ☐ Temp ill person ☐

Currently providing care or shelter for any children under the age of 6? **Yes** ☐ **No** ☐

Childcare in place for all children, including 6+ years of age, in your care? **Yes** ☐ **No** ☐

EDUCATION—Highest Level

H.S. Diploma/GED ☐ Trade/Other Cert ☐ Associates ☐ Bachelor's ☐ Graduate ☐

CRIMINAL JUSTICE INVOLVEMENT

Have you ever been convicted of a crime? **Yes** ☐ **No** ☐

Are you required to register for a sex offense? **Yes** ☐ **No** ☐

Do you have any upcoming court dates or unresolved legal matters? **Yes** ☐ **No** ☐

If yes, please explain: _____

If you are currently on community supervision (probation, parole, work release), complete:

- ❖ Time remaining: _____
- ❖ Case Manager: _____
- ❖ Phone: _____

What are your current requirements? Please list: *(classes, community service, restitution, fines)*

_____

_____

HEALTH HISTORY

Please answer the following questions regarding your ability to complete these tasks in the food service environment. *Please note: Having health concerns does not automatically bar you from participating at Work Options. Being connected to supports that improve your health is a key component to maintaining long term employment, which Work Options supports.*

If you have any allergies, please list: _____

_____

If yes, do you have an Epipen? **Yes** ☐ **No** ☐

Have you experienced chronic pain, injury ***or*** received treatment for a bodily injury/condition that would interfere with your ability to complete the physical tasks of the program? **Yes** ☐ **No** ☐

Have you ever been treated for a back problem or back related injury? **Yes** ☐ **No** ☐

Do you have any health concerns that may interfere with your ability to complete the training and gain/maintain employment in the food service industry? **Yes** ☐ **No** ☐

Have you ever experienced a mental or emotional health condition (depression, anxiety, suicidal thoughts, PTSD, hallucinations, strong feelings of anger)? **Yes** ☐ **No** ☐

Are you currently taking **any** medication that may cause side effects that can interfere with the program (drowsiness, diarrhea, insomnia, nausea, skin rash, etc.)? **Yes** ☐ **No** ☐

Are there any medications that you should be taking, but are not? **Yes** ☐ **No** ☐

If "yes," please list the medication and the side effects for each_____

_____

EMPLOYMENT HISTORY

Have you ever been employed? **Yes** ☐ **No** ☐ Last date of employment: _____

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

Why do you want to participate? _____

_____

_____

When are you available to start? ASAP ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 1 month ☐

The Work Options training will require me to repeatedly lift up to 50 lbs, to stand on my feet 7 hours a day, to move around and work with my hands and be in an environment that has hot and sharp items and is fast-paced. I also understand that I will engage in tasks that require a full range of motion, including, but not limited to, twisting, turning and reaching. I can now and will be able to do all of these things safely during the duration of the program.

Signature **Date**

WORK OPTIONS
AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I,_____, hereby authorize Work Options to request the following information concerning myself and my dependent children on a need-to- know basis for investigatory and case management purposes. Agencies and providers who request/provide information under this release may use a copy or a facsimile of this form in place of the original signed consent form.

Please place and "x" when choosing per:

_____ Child Welfare

___x___Public Assistance/ Workforce

_____ Medical and/or Mental Health

_____ Substance Abuse Treatment

_____ Vocational Rehabilitation

___x___Employment/Payroll

___x___Criminal Justice

_____Education

Other Agency:

AGENCY/PROVIDER NAME & PHONE	DATE ADDED	CLIENT SIGNATURE

The information exchanged may not be used as evidence in a criminal proceeding nor be used to investigate or prosecute a suspected crime, unless such documents are subpoenaed through a court order.

I understand that any records or alcohol and drug treatment are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, Part 2 of Title 42 of the Code of Federal Regulations and that recipients of this information may share it only in connection with their official duties.

This consent automatically ends one year from the date I sign this form or when the sharing of information is no longer needed to manage or provide services to me, or when I revoke my consent, whichever occurs sooner, except to the extent that the program or person authorized to make the disclosure has already acted in reliance on this consent. I understand I may revoke this authorization at any time by signing the revocation statement below and provide this document to Work Options.

This authorization for information sharing has been explained to me. I have read it (or it was read to me) and understand its provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit the sharing of information. I hereby willingly agree to share information as described above.

_____ _____

Date **Signature of Client**

_____ _____

Date **Signature of Work Options Staff & Title**

*** SIGN BELOW TO **REVOKE** RELEASE OF INFORMATION ***

I hereby revoke my authorization and consent for release of information to the parties listed on this form:

Revocation Date_____ Signature of Client _____

FOR STAFF USE ONLY

Possible Enrollment Date:_____

Reasons, motivation, interest	Notes_____
Challenges that may impede training completion and employment	Employment Eligibility Housing Transportation Care Giving Safety Education Collateral Consequences Health Other:_____ Notes_____
Follow Up Items	Employment Eligibility Housing Transportation Caregiving Safety Education Collateral Consequences Health Other:_____ Notes: _____