

Original Completion Date:  
 Updated on:  
 Updated on:  
 Updated on:

<b>INDIVIDUALIZED EMPLOYMENT PROFILE</b>			
<i>This document must be completed within the first 30 days of service.</i>			
Program		Start Date	
Staff		Referred by	

**SECTION 1: Personal Information, Employment, Education, References**

Name	Date of Birth	18 or older	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current Address			
Phone	Email		
Social Security #	State ID #	Driver's License #	
Previous Address			
Emergency Contact	Relationship	Phone #	
Address			

EDUCATION	Name/Location of School	Major and Years Attended	Degree
High School			
College			
Graduate Study			
Other			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently working towards an education goal?		
	<input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> Improving Literacy <input type="checkbox"/> Improving Language <input type="checkbox"/> Specialized Training (certificate pgm)		
	<input type="checkbox"/> College (Associates, Bachelors, Masters, Doctorate) <input type="checkbox"/> Other		
What kind of education would you need to obtain in order to get the job you want?			
What assistance do you need in attaining that education?			
How did you do in school? Were you in any special classes (honors classes or classes to help you learn better)?			

U.S. Military Service – Branch (Rank, Type of Duty, Type of Discharge, Special Training)
1.
2.

WORK HISTORY (beginning with most recent/current)			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently working? If Yes, # of hours/week		
Employer Name	Employed From (mo/yr):	To:	
Position	Supervisor Name	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for Leaving	Supervisor Phone		
Employer Name	Employed From (mo/yr):	To:	
Position	Supervisor Name	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for Leaving	Supervisor Phone		
Employer Name	Employed From (mo/yr):	To:	
Position	Supervisor Name	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for Leaving	Supervisor Phone		

Volunteering: Location/Organization	Time Period	Duties

<b>PERSONAL REFERENCES</b> – List three persons not related to you, whom you have known at least one year.			
Name	Phone #	Relationship	Years Known

<b>EMPLOYMENT</b>	
Do you know what type of work you are looking for? <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> 3 <sup>rd</sup> Shift/Overnight <input type="checkbox"/> Doesn't Matter	
Type of Position(s) Desired	Salary Desired /hr
Date Available to Start	# of Hours you would like to work
List any special skills or knowledge you have which will help you get a job (include tools and machines)?	
1. What do you like about working?	
2. What do you dislike about working?	
3. What are your long-term career goals?	
4. What type of work would you like to do now? What appeals to you about that type of work?	
5. What type of job/work would you <u>NOT</u> like?	
6. List skills learned from working, volunteering or life experience.	
7. Do you know people who are working? What types of jobs? What do you think about those jobs?	
8. What do you think work will do for you personally, financially, and socially?	

**SECTION 2: Basic Needs & Daily Routines**

Monthly Income: \$	Monthly Benefits: \$	Check benefits you receive:	<input type="checkbox"/> SSI <input type="checkbox"/> SDA <input type="checkbox"/> TANF <input type="checkbox"/> SSDI <input type="checkbox"/> Military
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps/Bridge Card <input type="checkbox"/> I'm not sure		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you manage your own money?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like more information on how working may affect your benefits? If YES, referral to benefits planner made - <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you and your family have sufficient food (quantity & nutrition)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Do you have reliable and affordable childcare?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you and your family have adequate and reasonable housing?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have adequate transportation to get to work? <input type="checkbox"/> Local Bus System <input type="checkbox"/> Special Transportation <input type="checkbox"/> Have a vehicle <input type="checkbox"/> Family/Friends Drive Me <input type="checkbox"/> Need to find reliable transportation		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like more information on transportation options?		
What's a typical day like for you from the time you get up until the time you go to bed?			
What are your typical sleep hours?			

**SECTION 3: Support Systems**

Who do you spend time with? How often do you see them?			
How would you describe the way you get along with people?			
Would you care for a job that involves working with the public?			
Please describe the neighborhood and community where you live.			
Are there places in your neighborhood where you enjoy going?			
Do you belong to clubs, groups, a church?			
Who do you know that could assist you in your job search in some way (networking), i.e. family, friends, educators, previous employers, others.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a place to shower?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have clothes for interviews or for a job?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an alarm clock?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have two forms of ID?

**SECTION 4: Legal Issues**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any felony or misdemeanor convictions?		
<input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Type/Circumstances: /	Year: _____	Currently on Probation <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Type/Circumstances: /	Year: _____	Currently on Probation <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Type/Circumstances: /	Year: _____	Currently on Probation <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any current legal issues? If YES, please describe.		
How do you feel about explaining your criminal history/status or other legal issues to a prospective employer?			

**SECTION 5: Health**

Describe your overall physical health.	
What medications are you taking? Why is it prescribed? Are you taking as prescribed by the doctor? Do you experience any side effects? When do you take them?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you physically able to perform daily living activities without assistance?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have health issues that could hinder your work responsibilities? (i.e., lifting, standing for a long time, stamina)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have medical documentation supporting this or restricting your ability to work?
How much alcohol do you drink? How often?	
What drugs do you now use or have used in the past? How often?	
Has substance use affected your every day activities, including work?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you <u>currently</u> receiving substance use treatment? If YES, describe type of treatment and for how long.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Could you pass a drug screen if required by an employer?
Describe your overall mental health.	
Has anyone told you what type of mental illness you have? How did they describe it?	
How does this illness affect you?	
What are the first signs that you might be experiencing a symptom flare up?	
How do you cope with your symptoms?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any type of crisis/intervention plan, WRAP or other assistance if needed?
Do you have any problems with memory? Concentration? Problem-Solving? If so, what has helped you with those issues in the past?	

**SECTION 6: Program Services**

<b>Importance Ruler:</b> Work is.....	0	1	2	3	4	5	6	7	8	9	10
	Not important at all			Unsure		Somewhat Important				Very Important	
<b>Confidence Ruler:</b> Work is .....	0	1	2	3	4	5	6	7	8	9	10
	Not confident at all			Unsure		Somewhat Confident				Very Confident	

**Disclosure** (or use "Plan for Approaching Employers" Worksheet)

*Employment Specialist: Please explain that each person using supported employment services can decide whether or not their specialist will contact employers on their behalf.*

What might be some of the advantages of having an employment specialist contact employers on your behalf?
What might be some of the disadvantages?
Are there any things that you would <b>not</b> want your employment specialist to share with an employer?
Do you know whether or not you would like your specialist to go ahead and contact employers on your behalf? (It is okay to change your mind at any time.)

If you decided that the specialist should not contact employers, what things would you like him or her to do in order to help you find a job?

help with job leads

help filling out applications

help writing a resume

rides to job interviews

practice job interview questions and answers

other:

What are your expectations for this program/services?

What are your expectations for your Employment Specialist?

What do you feel your role/responsibility is in a job search?

What type of work do you think you would be good at?

What are barriers to employment for you?

Why do you want to work now?

Is there anything that worries you about going back to work?

Do you have any additional comments that you would like to add?

**SECTION 7: Profile Updates** (please provide any new information long with the date)

**Date:**

**Date:**

**Date:**

**Date:**

**SECTION 8: Action Plan** *Must be completed within **one month** of services. Add new action plan sheets as updated.*

*Must be reviewed on a quarterly basis or when goals, objectives and/or steps/activities are completed.*

Name	Completion Date
Overall Goal	

**OBJECTIVE 1**

Steps/Activities	Person(s) Responsible	Occurrence	Date Attained
Comments:			

**OBJECTIVE 2**

Steps/Activities	Person(s) Responsible	Occurrence	Date Attained
Comments:			

**OBJECTIVE 3**

Steps/Activities	Person(s) Responsible	Occurrence	Date Attained
Comments:			

**REVIEW SIGNATURES**

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

WFD Staff Signature \_\_\_\_\_ Date \_\_\_\_\_