SUBSTANCE USE DISORDER VOCATIONAL REHABILITATION READINESS ASSESSMENT FORM

INSTRUCTIONS: This report must be completed as part of an individual's eligibility referral to NYS Vocational & Educational Services for Individuals with Disabilities (VESID). The report must be completed by one of the following Qualified Healthcare Professionals in OASAS licensed treatment programs: MD, Ph.D, Licensed Psychologist, CSW, CRC, LMHC and CASAC. If a psychiatric condition exists, in addition to this report, the completed Psychiatric Disability (VES-119) Form is to be included along with a copy of a recent physical examination, if available.

Name_____ Age: _____ E-Mail: _____
Address: _____ Home Phone #: ( ) _____
_____ Cell Phone #: ( ) _____

Treatment Program name: _____
Treatment Program address: _____
Primary Counselor name: _____ Telephone #: _____
VR Counselor name: _____ Telephone #: _____
Diagnosis: _____
DSS Contact name: _____ Telephone #: _____
Parole/Probation Contact name: _____Phone #: _____
Source of support (Wages, PA, SSI, Family, etc.) & amount: _____
Medical insurance ___Y ___N
If yes, please specify type: _____

Reason for referral to ACCES-VR
_____
_____
_____
_____

I) Addiction History: Past and Present information

Age of onset of abuse: _____

Please check all substances abused:
____ Alcohol
____ Cocaine/crack
____ Heroin/opiates
____ Marijuana
____ Methamphetamine
____ Other (please specify): _____

Longest period of continuous sobriety/abstinence:
_____
_____

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Date of last known substance use: _____

Describe addiction history including time frames of relapse:.

_____

_____

_____

Describe current family support for the individual's alcohol/substance abuse treatment.

_____

Describe progress made in compliance with treatment goals:

_____

_____

_____

Recovery Supports/Sober Support Network:
List self-help programs that the individual actively attends (e.g., AA, NA):

_____

Does the individual have a sponsor?
Yes: _____ No: _____

Reported medical / health issues:

_____

_____

Reported family issues:

_____

_____

_____

Reported employment issues:

_____

_____

_____

Reported educational issues:

_____

_____

_____

Is the individual on parole, probation, or mandated into treatment?
Yes: _____ No: _____

Does the individual report a misdemeanor criminal history?
Yes: _____ No: _____

If yes, please describe conditions of parole or probation:

_____

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_____
_____
_____

Does the individual report a felony criminal history?
Yes: _____ No: _____

If yes, please describe conditions of parole or probation:
_____
_____
_____

II) Work-Readiness Checklist

This checklist will help to identify an individual's readiness to engage in the VESID Vocational Rehabilitation process. This is defined as the ability to actively participate in the exploration, planning, training and/or employment activities to obtain and maintain gainful employment.

Is the individual participating in a DSS or other mandated activity which may interfere with VESID participation?
Yes: _____ No: _____

If yes, please specify_____

Does the individual have legal work status in the United States?
Yes: _____ No: _____

If yes, please indicate documentation(s) provided demonstrating legal work privileges (indicate expiration date of document(s), if applicable):
_____
_____

Has the individual expressed and demonstrated motivation or a desire to work?
Yes: _____ No: _____

Which of the following modes of transportation can this individual use independently? Check all that apply.
____ Public transportation ____ Para transit ____ Own Vehicle
____ OTHER (please describe):
_____

Will the individual have reliable childcare/eldercare arrangements in place, if appropriate?
Yes: _____ No: _____ N/A: _____

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Have all known pending medical issues been addressed (e.g., visual, dental, auditory, prosthesis, etc.)?
Yes: _____ No: _____

Will the individual have ongoing treatment/medical requirements coordinated with a training/work schedule?
Yes: _____ No: _____

Is the individual compliant with all known prescribed medications?
Yes: _____ No: _____

Does the individual practice appropriate hygiene?
Yes: _____ No: _____

Does the individual have stable housing (includes residential treatment/shelter setting)?
Yes: _____ No: _____

Are any proposed changes in living arrangements planned for the near future?
Yes: _____ No: _____

If yes, please describe: _____
_____

Which valid forms of identification does the individual possess? Check all that apply.

Non-Driver's ID ( )	Driver's license ( )	Military Identification ( )
Social Security card ( )	Birth Certificate ( )	Medicaid Card ( )
Passport ( )	Citizenship Documents ( )	Alien Registration/Green Card ( )

OTHER ( ) – (please indicate type of identification provided): _____

Does the individual have an updated resume?
Yes: _____ No: _____

If yes, please attach.

Can the individual complete a job application independently?
Yes: _____ No: _____

Does the individual accept supervision?
Yes: _____ No: _____

Does the individual get along with others?
Yes: _____ No: _____

Please rate the following in relation to treatment program participation:
<u>Punctuality</u>

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1	2	3	4	5
Very Poor	Poor	Unsure	Good	Very Good

Attendance

1	2	3	4	5
Very Poor	Poor	Unsure	Good	Very Good

Does the individual have reported/demonstrated transferable work skills?
Yes: _____ No: _____

If yes, please describe.
_____
_____
_____

Has the individual identified a specific job goal?
Yes: _____ No: _____

If yes, please describe:
_____
_____

Has the individual defined his/her geographic preferences for work?
Yes: _____ No: _____

If yes, please specify where: _____

Is the individual currently involved (or has been involved) in a work activity (volunteer or paid) or apprenticeship?
Yes: _____ No: _____

If yes, please describe:
_____
_____

Does the individual require any workplace accommodations?
Yes: _____ No: _____

If yes, please describe:
_____
_____

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ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature of Qualified Treatment Professional (MD, Ph.D, MSW, CRC, LMHC, CASAC)

Date

_____

Phone Number