

Assessment for Referral to Atlanta Workforce Development Agency
(To be completed by case manager)

Name: _____ Date _____

Social : _____

Address: _____

Phone : _____ Alt Number: _____

Referring Agency: _____

Case Manager: _____ Phone Number: _____

Please have customer bring these items:

Identification:	Yes	No	
Valid GA DL	___	___	If "No" Why: _____
SSC	___	___	
Birth Cert	___	___	
Proof of Residence	___	___	
Food Stamp or General Assist	___	___	

General Information:

Do you have transportation? Please explain _____

How long have you been homeless? _____

Criminal History:

Have you ever been convicted of a crime? _____

On probation? _____

Are you bonded with Dept of Labor? _____

If not, please go to the Atlanta South Metro Department of Labor 2636-14 MLK Jr., Drive (404-699-6900) any Thursday at 9:00 to attend the TOP STEP CLASS.

History of Substance Abuse:

Are you clean and sober? If so, how long? _____

Would you be willing to submit to random drug test? _____

If No, please seek treatment before continuing this process.

Are you currently in Treatment? If so, please explain _____

History of Physical or Mental Health Disorders: _____

Why do you believe you are a good candidate to participate in this program? _____

Please bring this completed form to Atlanta Workforce Development Agency 818 Pollard Blvd Atlanta, GA 30315 to Orientation
Monday, Wed, Thurs at 8:15

**** PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW ****

AUTHORIZATION TO DISCLOSE INFORMATION TO

**Jennifer Moore, Program Manager
Atlanta Workforce Development Agency
404-230-1198**

To be completed and signed by the case manager:

I voluntarily authorize disclosure (including paper, oral, and electronic interchange) of all medical and education records, as well as any other information related to the customer's ability to perform tasks. This includes specific permission to release:

- 1.** All records and other information regarding treatment, hospitalization, and outpatient care for impairment(s) *including*, and not limited to:
 - a)** Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - b)** Drug abuse, alcoholism, or other substance abuse
- 2.** Information about how the customer's impairment(s) affect(s) their ability to complete tasks, activities of daily living and their ability to work.
- 3.** Copies of teachers' observations and evaluations, educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, as well as any other records that can help evaluate function.
- 4.** Information created within 12 months after the date this authorization is signed, as well as past information.

Case Manager Signature

Date

This information will be used for the sole purpose of effective case management and collaboration of resources to best serve the customer. This authorization is good for 12 months from the date signed.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

Customer Signature

Program Manager Signature