## Verification of Disability for Job Placement

Dear Psychologist/Psychiatrist,

SOAR365® is a 501(c)(3) non-profit organization with a mission to support people with disabilities in leading productive and fulfilling lives. SOAR365's® AbilityOne Program, established by the Javits-Wagner-O'Day Act, provides employment opportunities for Americans with significant disabilities. Among the requirements for SOAR365® to participate in the AbilityOne program, is that 75% of its total direct labor hours must be performed by people who are ***blind or severely disabled.***

Your patient listed below is applying for a job at SOAR365®. We would appreciate your assistance in providing relevant information about your patient's disability as it relates to employment. **SOAR365®** ***is required to have verification of disability signed by a licensed medical doctor or mental health professional capable of making the evaluation stating all diagnoses in order for the candidate to be considered for employment.***

*****Please note: All 3 pages must be returned, and the Provider MUST sign page 3*****

If you have concerns regarding the release of this information, please contact Kendall Solo at (804) 665-1200.

Thank you in advance for your support.

Sincerely,
SOAR365®

**APPLICANT:**
**PLEASE SIGN HERE BEFORE FORWARDING TO YOUR PROVIDER**

I, ____________________________ give my permission to release medical and/or disability related

information to SOAR365® for the purpose of determining my eligibility for employment

services, under the AbilityOne program.

**Signature**: __________________________________ **Date:** ______________________

| Psychological / Psychiatric Assessment |
|---|

| Patient Name: | Date: |
|---|---|
| Patients DOB: | |

| Name of Provider Completing Form: | | |
|---|---|---|
| Phone #: | E-mail: | |
| Credentials: ☐ Psychologist | ☐ Psychiatrist | ☐ Other |

*Your cooperation in completing this form is vital to our efforts in determining your patient's eligibility for employment within the AbilityOne program, and assessing the supports / accommodations that may be needed.*

| **Diagnosis:** Present at this time |
|---|
| • <br> • <br> • <br> • |

| **Medications:** | | |
|---|---|---|
| Prescribed | Indications (Purpose) | Side Effects |
| | | |

**Has your patient recently experienced any changes in medication/health status?**

**Is your patient's condition expected to be permanent or temporary?**

**If temporary, how long is the condition expected to last?**

Please describe your patient's ability to perform each activity according to the following terms:
**Good:** Ability to function
**Fair:** Ability to function is seriously limited but not precluded
**Poor:** No ability to function

| Mental Ability | Good | Fair | Poor |
|---|---|---|---|
| Interact appropriately with people | ☐ | ☐ | ☐ |
| Maintain socially appropriate behavior | ☐ | ☐ | ☐ |
| Adhere to basic hygiene standards | ☐ | ☐ | ☐ |
| Travel independently | ☐ | ☐ | ☐ |
| Understand and remember instructions | ☐ | ☐ | ☐ |
| Carry out simple tasks | ☐ | ☐ | ☐ |
| Maintain adequate concentration (<2hrs) | ☐ | ☐ | ☐ |
| Adhere to work schedules (punctuality & attendance) | ☐ | ☐ | ☐ |
| Perform job duties without special supervision | ☐ | ☐ | ☐ |
| Work in coordination with or proximity to others without becoming distracted | ☐ | ☐ | ☐ |
| Able to make independent decisions | ☐ | ☐ | ☐ |
| Perform at a consistent pace | ☐ | ☐ | ☐ |
| Request assistance from others when needed | ☐ | ☐ | ☐ |
| Deal with normal work stress | ☐ | ☐ | ☐ |
| Be aware of normal hazards and take appropriate precautions | ☐ | ☐ | ☐ |

**Additional Comments:**

*If your medical file contains a psychological evaluation or psychiatric evaluation, please include it as supporting documentation.*

**Physician Information (Please print clearly)**

Practice Name and Address: ______________________________________________

______________________________________________

Practice Specialty: ______________________________________________

Signature: ______________________ Date: ______________________

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