Ability Solutions, Inc. Information Packet

PLEASE PRINT CLEARLY

1111 W. Ledbetter Dr., Suite #900, Dallas, TX 75224
Phone: (972) 283-6670 Fax: (972) 296-0068
Email: info@abilitysolutions.org

Customer Information Packet

Welcome to Ability Solutions!

We are excited you have chosen Ability Solutions. Inc. as your **Ticket to Work Program** Provider. We are dedicated to providing high-Quality services which in hand will create successful outcomes within your life long goals.

We have a specially trained and dedicated team that will always go the extra mile to provide the absolute BEST customer service, ensuring that you training and transitioning is as smooth as possible.

Please take a moment to familiarize yourself with the enclosed agreement and other documents.

Please include a copy of your resume or a summary of previous employment. You may also email your resume to **info@abilitysolutions.org**

Please sign and return the signature page and other documents in the envelope included. If you have any questions, please feel free to contact us.

On behalf of all of us at Ability Solutions, thank you for giving us the opportunity to serve your needs and we look forward to working with you!

Best Regards,

April Watson-Horton
Chief Executive Officer
Ability Solutions, Inc.

Shamequia Cason
Ticket to Work Director
Ability Solutions, Inc.

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Full Name	
Address	
City, State, Zip	
E-Mail	

Home Phone	( ) -	**Date of Birth**	/ /
Date of Birth	( ) -	**Social Sec #**	- -
Cell Phone		**Gender**	

Do you have unexpired State issued Driver's License _____ or Identification Card_____?

Are you a veteran? _____ If yes, which Branch? _____ MOS_____

Honorable Discharge? _____ Dates of Activity: _____ to _____.

Do you have a resume? ☐ Yes ☐ No (See attached from or send most current)

Do you have access to a computer and/or laptop? _____ Will you need job accommodations? _____.

What form of transportation will you use? Own car_____ family/Friends ____public Transportation_____

Please list your disability (IES):

_____ _____

_____ _____

_____ _____

How does your disability (IES) affect you working?

Do you have restrictions from your Doctor?

What kind of guidance do you need? (Ex: Interviewing skills, assistance with applications)

Are other current issues or challenges that may impact your work goals?

Have you ever been arrested and/or convicted of a crime that may affect you working? Yes__ No_ If yes, describes and provides details. (Ex: Date, Crime, Traffic, Felony, Probation, Parole, etc.)

In the next 3-12 months how much is the lowest amounting that you will accept for pay?

Hourly $_____ Monthly $_____ Annually $_____

Do you have any limitations, besides scheduled doctor appointments that you cannot work?
(For example: No overnights, religion)

The Ticket to Work program is set up so that you may become Income Self-Sufficient and eventually no longer rely on your SSA Cash Benefits. Are you ready for full-time (32-40 hours per week) work?

Yes☐ No☐ If No, Describe:

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What type of job (industry) are you looking for? (Please check)

☐Janitorial	☐Telephone Customer Service	☐Security
☐Retail	☐Food Service	☐Warehouse
☐Hotel	☐Office Administrative/Clerical Education	☐transportation
☐Banking	☐Education	☐Social Services
☐Housekeeping	☐Customer Service	☐Grocery
☐Skilled Trade_____	☐ Health Care _____	
☐ Professional_____	☐ Work from Home_____	

☐Other: _____

What hours of work do you prefer? _____

Do you prefer to work independently or as part of a team? _____

What are your immediate or short-term work goals? (Within 3-12 months)._____

_____

Where do you see yourself in 3-5 years in your success with your work goals? _____

_____

Who may we contact if we cannot reach you?

First and Last Name	**Relationship**	**Telephone Number**
_____	_____	_____
_____	_____	_____

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Consent Form
Please Print

Name: _____

Date of Birth: _____/_____/_____

Social Security Number: _____

Contact Number: _____

Federal law requires this consent form be provided to you. Unless authorized by law, we cannot use or collect, without your consent, your employment history or financial wages information for the program in which you are participating. A photocopy of this authorization is fully acceptable as an original.

Entity Authorized to Disclose

As a customer I authorize the provider listed below to disclose the protected health information and other personal information listed under "Information Subject to Disclosure" to Ability Solutions, Inc.

The Work Number
and/or

Employer: _____

Any information collected may not be disclosed or used by Ability Solutions, Inc. for any other purpose other than that permitted by this consent document. Your consent is valid for the amount of time that your case is active with Ability Solutions, Inc. or until requested in writing without consequence to cease usage.

All information retained will be strictly confidential.

I have received a copy of this consent for my own records and I agree.

Signature: _____ Date: _____

Education and Employment History

***Please complete so that your resume can be created or updated,
This will also assist when completing applications.

PLEASE PRINT CLEARLY

NAME: _____

EDUCATION

Type	Name of school	City, State	Did you Graduate?	MM/YYY	Diploma/Degree/Certificate/ Subject
High school					
College or university					
College or university					
Trade school/ other					

EMPLOYMENT HISTORY

****List most RECENT jobs first. Enter dates as MM/DD/YYYY**

1. Employer	**Dates**		**Are you eligible for rehire?**
	From	**To**	
Full address			**Reason for leaving**
Telephone	**Hourly Rate/salary**		**Duties**
	Starting	**Final**	
Job title			
Supervisor			
2. Employer	**Dates**		**Are you eligible for Rehire?**
	From	**To**	
Full address			**Reason for leaving**
Telephone	**Hourly Rate/salary**		**Duties**
	Starting	**Final**	
Job title			

Supervisor			
3. Employer	**Dates**		**Are you eligible for rehire?**
	From	**To**	
Full address			**Reason for leaving**
Telephone	**Hourly Rate/Salary**		**Duties**
	Starting	**Final**	
Job title			
4. Employer	**Dates**		**Are you eligible for rehire?**
	From	**To**	
Full Address			**Reason for leaving**
Telephone	**Hourly Rate/Salary**		**Duties**
	Starting	**Final**	
Job title			
Supervisor			

Tell us what do you do well? *Current License or Certifications

Please check all that apply:

☐	**CDL Drivers license**	☐	**Microsoft Word**	☐	**Foreign language:**
R	**Class Drivers License**	☐	**Microsoft Excel**	☐	**Time Management**
☐	**Internet Research**	☐	**Microsoft Publisher**	☐	**Teamwork**
☐	**Inbound calls: Sales/Cs**	☐	**Microsoft Access**	☐	**Date Entry: KMP**
☐	**Forklift Certified Stand-up**	☐	**Microsoft outlook**	☐	**Typing: WPM**
☐	**Forklift Certified Sit Down**	☐	**Written Communication**	☐	**Multiple Telephone Lines**
☐	**Forklift Certified**	☐	**Customer Service**	☐	**Hands on Learner**
☐	**Technical Competency**	☐	**Google Sheets**	☐	**Willing To Learn**

☐	**CPR Certified**	☐	**First Ad Certified**	☐	**Outbound Calls: Sales/ CS**
☐	**Management:**	☐	**Chas, cheque, Credit card, handlings kills**	☐	**Nursing:**
☐	**Security Non-Commissioned**	☐	**Security commissioned**	☐	**Social Services**
☐	**Housekeeping**	☐	**porter**	☐	**Receptionist**
☐	**Small Machinery**	☐	**Heavy Machinery**	☐	**Valet/Delivery/Driver**

PERSONAL REFERENCES

(Not Former Employers or Relatives)

Full Name	Telephone	Years Known	Occupation

BACKGROUND

NOTE: If you worked under a different name (i.e. maiden name) at any of these employers or schools.

Part Three: IWP Terms and Conditions

The following terms and conditions apply to the EN and the Ticketholder identified in Part One above:

1.) The EN and the Ticketholder shall inform one another immediately of any changes in the contact information shown in Part One above.

2.) The Ticketholder shall report all earnings to the EN and to Social Security.

3.) The Ticketholder shall authorize the EN to contact employers on the Ticketholder's behalf, as necessary, to verify or obtain evidence of the Ticketholder's work and earnings.

4.) The EN may not request or accept compensation from the Ticketholder for the costs of services and supports provided the Ticketholder under the IWP.

5.) The EN shall use only qualified employees and/or providers to provide supports and services to the Ticketholder.

6.) The EN shall establish and explain to the Ticketholder a process to resolve any disputes that arise under this IWP, including the process for escalating an unresolved dispute to Social Security.

7.) The EN shall inform the Ticketholder of the availability of, and contact information for, free protection and advocacy services under the Protection and Advocacy for Beneficiaries of Social Security program.

8.) The EN shall inform the Ticketholder of annual Timely Progress Reviews (TPR) performed by Social Security to assess the Ticketholder's work progress, and explain to the Ticketholder the TPR guidelines.

9.) The EN shall keep private and confidential the Ticketholder's personal information, including his or her Social Security Number and disability, and shall maintain all private and confidential information in a secure area.

10.) The EN shall provide the Ticketholder with a copy of the completed IWP, as well as any subsequent changes to the IWP, in the Ticketholder's preferred format.

11.) Both the Ticketholder and the EN must agree to any change to the IWP. All changes to the IWP must be in writing and supported by evidence of mutual consent.

12.) The EN shall provide the Ticketholder with a copy of his or her EN file upon request.

13.) Either the Ticketholder or the EN may choose unilaterally to un-assign the Ticket at any time by notifying the other in writing, thereby terminating the Ticketholder-EN relationship established by the IWP.

14.) Upon approval of the IWP by both the Ticketholder and the EN, the Ticketholder acknowledges assignment of his or her Ticket to the EN and the EN acknowledges acceptance of that Ticket.

15.) Are there any other terms and conditions relating to the implementation and administration of this IWP?

☐ Yes ☐ No

If "Yes," list additional terms and conditions:

I choose to participate in the Ticket to Work Program with the Employment Network (EN) named below. I understand that my EN will provide me employment support to help me find a job, increase my earnings, and reduce my reliance on cash benefits. I have read and understand the requirements, obligations, terms, and conditions expressed in this IWP. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Ticketholder's Signature:_____ Date:_____

EN Representative's Signature:_____ Date:_____

EN Name:

Consent for Release of Information

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). You may complete this form to release only the minor's non-medical records, if you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child. We require proof of relationship, if you are not the subject of the record. We may charge a fee for providing the information, if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act. If you are requesting information, such as a Social Security Statement or benefit verification letter, you can also access this information by creating an account at https://www.ssa.gov/myaccount/.

NOTE: **Do NOT use this form to request:**

- **The release of a minor child's medical records. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or**
- **Detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.**

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in the name, date of birth, and social security number of the subject of the record.
- Fill in the name and address of the person or organization of where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., litigation, investigation, determining eligibility for benefits). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child or legally incompetent adult, you must state how the release of information is in the best interest of the minor child or legally incompetent adult.
- Check the box next to the type(s) of information you want us to release including specific date ranges, where applicable.

NOTE: Unless otherwise specified, the consent form is valid for one-time use only. Also, it is valid for one year from the date of signature, unless you are requesting medical records. A consent form that includes a request for medical records is valid for 90 days from the date of signature.

Send or bring the completed form to the subject of the record's local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input the subject of the record's ZIP code.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

***ADDRESS OF PERSON OR ORGANIZATION:**
**** PHONE NUMBER OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☐ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

****Relationship (if not the subject of the record):** _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address (Number and street,City,State, and ZIP Code)	Address (Number and street,City,State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. 552a) and Section 205(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from honoring the request to release information or records about you. We will use the information you provide to respond to the request for Social Security Administration (SSA) records. We may share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0340, entitled FOIA and Privacy Act Record Request and Appeal System, as published in the FR on July 13, 2016, at 81 FR 45352. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***