Georgia Transplant Foundation

Enriching Lives Everyday

JumpStart – Transition to Employment

What you can expect from us:

- A four-month program with services tailored to meet the unique needs of the Georgia transplant community.
- Customized career coaching specific to you and your career level.
- Assistance with identifying your career options and defining your job search goals.
- One-on-one coaching to teach you how to launch a successful job search and market your talents.
- Availability of skills assessment tools, educational resources and financial planning referrals.
- Information on applicable Social Security Administration programs
- Referrals to career development services and partnerships
- ADA information and worksite modification planning.

What we cannot do:

- We are not a placement service and cannot find a job for you.
- We cannot make career decisions for you.
- We are not able to make labor market predictions.

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JUMPSTART - REFERRAL FORM

Date: _____ ***Referral Source:*** _____

Pre/Post Transplant/Other: _____ ***Social Worker:*** _____

_____

Organ: _____ ***Transplant Center:*** _____

Transplant Date: _____ ***DOB:*** _____

Name: _____

Home phone: _____ ***Cell phone:*** _____

Address: _____

_____

County: _____ ***Email:*** _____

Have you received a "Ticket to Work" from the Social Security Administration?

Yes _____ ***No***_____

Previous job(s): _____

Vocational goal or job interest: _____

Current means of financial support: _____

Comments: _____

_____

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Providing this information will not adversely affect any consideration you may receive for GTF services.

CLIENT INFORMATION:

_____
First Name Middle Last Name

_____
Street Address Apt/ Suite Number

_____
City State Zip Code County

_____ _____ _____
Home Phone Cell Phone E-mail Address

_____Male _____Female Marital Status _____ Spouse's Name _____

_____ _____ _____ _____
Date of Birth Age Number in household Number of Children

DEMOGRAPHIC INFORMATION:

_____ _____ _____
Transplant Center Date of Transplant Organ

_____
Follow-up Care

Race Optional (Please Check): _____ Hispanic _____ African American _____ White, Non-Hispanic
_____ Asian Pacific Islander _____ American Indian, Alaskan Native _____ Other

Level of Education Optional (Please Check): _____GED, _____ attended High School (number of years____),
_____ High School Graduate, _____ Technical Certificate / Diploma, College (number of years_____),
_____, Bachelors _____ Masters, _____PhD

Current Source of Income: (Please check all that apply) _____ Full time employment _____ with benefits
_____ Part-time employment _____ with benefits, _____ Part-time employment without benefits,
_____ Retirement pension, _____Working spouse, _____ Social Security Retirement,
_____ Social Security Disability (SSDI), _____ Supplemental Security Income (SSI)

Work Status (Please check): _____Currently employed, Employer Name _____
_____Medically Disabled _____, _____Retired, _____ Unemployed _____
Date Date

Current Source of Healthcare Coverage :(Please check all that apply) ____Insurance ____ Spouse's Insurance
____Medicare ____Medicaid ____QMB Medicaid ____ Spend-down Medicaid ____ COBRA

Check all that apply:

☐ Recipient ☐ Candidate ☐ Living donor ☐ JumpStart Client ☐ Wellness Conference Attendee
☐Workshop attendee ☐ Mentor with Mentor Project ☐ GTF Volunteer/Board Member/Committee Member

How did you hear about GTF Services? GTF Website/Newsletter/Brochure _____
GTF Staff Name _____ GTF Volunteer, Name_____
Transplant Center Staff, Name _____

CLIENT INTAKE

Providing this information will not adversely affect any consideration you may receive for GTF services. Complete information allows us to better serve our clients.

PLEASE PRINT

CLIENT INTAKE **DATE:** _____

Name: _____ Phone: ( ) _____ ( ) _____
Home Cell

E-mail Address: _____

Address: _____ County: _____

Date of Birth: ___/_____/____ Age: _____ Gender: Male / Female

Marital Status: _____Number of Dependents: _____

Type of Transplant: _____ Date of Transplant: _____Transplant Center: _____

Are you a *Ticket Holder* from the "Ticket-to Work" program? Yes____ No___

Are you receiving assistance from the Georgia Transplant Foundation? Yes_____ No_____

Employment History (**Please list most recent first)**

Dates	Company Name	City & State	Position	Wage

1. _____
2. _____
3. _____
4. _____
5. _____

Educational Background

School	City & State	Major	Degree/Diploma/Certificate

1. _____
2. _____

Type of disability: _____

How does it affect your ability to work? _____

_____

Social Security Number: _____ / _____ / _____

Receiving SSI or SSDI benefits? Yes/No

Total family Income: _____

Career Objective:_____

Skills / abilities currently possessed for the career interested in: _____

_____

Salary Desired: _____ Minimum Salary Required _____

Geographic area willing to work:

_____

Transportation available? YES_____ NO_____

Criminal record? This information is confidential and needed for your private counseling sessions with your assigned JumpStart Counselor.

YES_____ NO_____

Explain:_____

Career Plan: (Career Counselor only)

_____

_____

_____

_____

_____

I attest the information above information above is accurate and true to my knowledge:

Signature: _____ Date: _____

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RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the source of my referral and all previous and current and / or prospective employers, to release to Georgia Transplant Foundation, ***("GTF")*** *or its staff, all information concerning my vocational, diagnostic and other related activities.*

I hereby authorize ***GTF*** *and its staff to release all information concerning my vocational activities to prospective employers, the source of my referral and Rehabilitation Services Accreditation System,* ***("RSAS").***

I also authorize ***GTF*** *to release the results of diagnostic testing, such as general aptitude testing batteries, career interest testing, work and vocational evaluations performed by medical staff and psychological evaluations ordered by the Georgia State Department of Vocational Rehabilitation Services, and to release a copy of my medical records to the Georgia State Department of Vocational Rehabilitation Services.*

In addition, I authorize the above information in paragraph #1 to be used anonymously for statistical reporting.

I release ***GTF*** *and its staff from any liability for damage which may result from either obtaining or releasing the aforementioned information.*

A duplicate copy of this document shall serve as equally effective as the original in the authorization of release of information.

The above mentioned consent may be withdrawn at any time upon written notification of such to ***GTF,*** *except to the extent that* ***GTF*** *has previously relied upon such consent.*

I understand that I have the right to participate in and appeal any services that I am not happy with in my vocational plan with ***GTF*** *and the Georgia State Department of Vocational Rehabilitation Services.*

Date of Birth _____/ _____/_____

Social Security Number _____/ _____/_____

_____ _____/_____/_____

Client Signature *Date*

_____ _____/_____/_____

Georgia Transplant Foundation *Date*

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CLIENT CONTRACT

A program to assist_____ Social Security No._____

CIVIL RIGHTS*:*

I understand I will not be refused services because of my age, race, sex, or religion.

PARTICIPANT'S RIGHTS:

The Participant Rights have been explained to me as well as I have received a written copy of the rights.

PARTICIPANTS GRIEVANCE:

The policies and procedures for handling a grievance have been explained to me as well as I have received a written copy of the plan.

MY RESPONSIBILITIES:

I will work with my career counselor to decide the specific things I will be responsible for in completing my career goal. If I do not follow through with my responsibilities as agreed upon in my planning my services may be stopped.

_____ _____

Client Signature *Date*

_____ _____

JumpStart Career Counselor Signature *Date*

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GEORGIA TRANSPLANT FOUNDATION'S POLICIES AND PROCEDURES

Section:	Category:	Effective Date:
JumpStart Vocational Rehabilitation	Individual Program Planning And Management	9-1-00

TITLE: Policies and Procedures for Handling a Participant Grievance

PURPOSE: To define the grievance and appeal process protecting the rights of an individual.

POLICY: Formal grievance procedures are established which give an individual the opportunity to be heard in a dispute and the right to challenge a decision. The Georgia Transplant Foundation (GTF) strongly encourages that each grievance be addressed as efficiently as possible in order to secure the rights of all persons and to ensure quality services are offered.

1. The individual who chooses to challenge or appeal a decision should talk first to the person who made the decision. Holding a conference at this level can be done informally. It is felt that most problems can be worked out or more clearly understood if discussions take place at the lowest level possible..

2. If still not satisfied, the individual may appeal to GTF's Executive Director. This appeal, if possible, is to be submitted in writing. All parties involved may be interviewed. A written decision will be presented within two working days of the appeal.

3. If the issue continues not to be resolved and all of the above have been addressed, the individual has a right to appeal to GTF's Appeal Board, which consists of one member of GTF's Board of Directors, one participant client of GTF, and the Director of Patient Services. This is to be done five days after talking to the person who made the decision. The Appeals Board will meet within five working days of notification of the appeal. All patients involved will be heard. The Appeal Board will render a written decision of the board within three working days.

4. If a need arises at any GTF stage of a grievance and appeals process, GTF can assist the individual with interpreting services through the Georgia Interpreting Services Network (404-521-9100).

5. Depending on the circumstances of the grievance and availability of staff, there may be occasions where individuals hearing grievances and sitting on the board may be changed. The Executive Director may substitute individuals as necessary.

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PARTICIPANT RIGHTS SUMMARY

By participating in this program, your rights are protected by the Georgia Transplant Foundation's (GTF) policies regarding Human Rights, Health and Safety. Below is a summary of these rights.

- The right to be considered for services regardless of age, gender, ethnicity, religion, nationality, or disability.
- The rights to receive services that respect your dignity protect your health, and safety.
- The right to confidentiality within the limits of the law.
- The right to be free of physical or verbal abuse.
- The right to review and obtain copies of your records generated by GTF.
- The right to participate in the planning of your own program.
- The right to know about changes in your program before they happen.
- The right to know of any decisions, which affect your case and the reasons for them.
- The right to appeal decisions.
- The right to accessibility and reasonable accommodations.
- Each and every participant and employee of GTF shall be treated with dignity, courtesy and respect. Furthermore, participant or employee abuse in any physical, mental, verbal, or other manner will not be tolerated. Abuse whether subtle or obvious, intended, or unintended is unacceptable.
- Violators of this policy will be subject to immediate disciplinary action and /or termination. It is the responsibility of the participants and employees to report to appropriate personnel (Supervisor) at any circumstances that may be viewed as abusive. Allegations of infringement will be documented.
- GTF upholds these rights and all rights covered under Sec. 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the United Nations General Assembly "Declaration on the Rights of Disabled People."

JUMPSTART CLIENT COPY

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PLEASE FAX OR MAIL OR E-MAIL THE FOLLOWING FORMS:

- **Client contract**
- **Release information**
- **Demographic form**
- **Intake form**

Fax number: 770-457-7916

Mailing address: Georgia Transplant Foundation
500 Sugar Mill Rd.
Building A, Suite 170
Atlanta, GA 30350

E-mail address: clafayette@gatransplant.org

Attention: Charlene Lafayette