Project | SEARCH

Seacoast New Hampshire

Student Application
2025-2026

Name:

Application Purpose & Guidelines

The purpose of this application is to enable the Selection Committee to assess each candidate's skills, abilities, background and desire to work. A parent, counselor, case manager, teacher or employer may be contacted by the Selection Committee in order to gather additional information. Our goal is to select SEARCH interns who will be successful in Project SEARCH and reach the goal of competitive employment.

The Selection Process includes the following guidelines:

1. All candidates are encouraged to attend an Info Session.
2. Submit the completed application **(part 1 and part 2)** and required documentation* by **March 7, 2025** to:

Carla Smith
Community Partners
113 Crosby Rd
Dover NH 03820

*Additional information must be submitted with the application in order to assess the potential for success in Project SEARCH. Samples include but are not limited to:

- IEP or ISA, Attendance Records, Assessments, and/or Evaluations
- **Two** completed reference forms

3. The Selection Committee will review the applications
4. Skills Assessments and Interviews will be held **March 11,12, 2025**

Please note:
The Selection Committee includes the Project SEARCH Instructor, a representative from Portsmouth Regional Hospital, a NH Vocational Rehabilitation counselor and Community Partners. Project SEARCH is a competitive program. Acceptance is NOT guaranteed.

The selection process will consider:

1. Candidates who desire to work competitively upon completion of the Project SEARCH program
2. Candidates who can use public transportation or other available transportation resources
3. Candidates who will benefit from participation in a variety of internships
4. Candidates who have finished their necessary credits for high school graduation
5. Only candidates who have completed the required hospital tour will be considered
6. Please refer to the Entrance Criteria for complete list of considerations

Deadlines and Timeline:

1. Application due: **March 7, 2025**
2. Interviews & Skills assessment held **March 11,12, 2025**
3. Acceptance letters mailed by: **March 21, 2025**
4. NH Vocational Rehabilitation cases opened by: **May 30, 2025**
5. The following items must be sent to Community Partners no later than **May 30, 2025**:
   - Government issued photo ID
   - Criminal Background Check Release Form
6. Drug screens and medical clearance must be completed at :
7. Occupational Health Services, 25 New Hampshire Avenue, Suite 105, Pease International Tradeport, Portsmouth, NH 03801 Call 603-430-9675 for an appointment
8. Students have the option of getting a flu shot or wearing a mask at the hospital from October to March.

PART 1:
Contact Information

Applicant Name:			_____ Middle	
Home Address:	_____ Street	_____ City	_____ State	_____ Zip Code
Email:				
Phone Number:				
Date of Birth:			☐ Male	☐ Female

Parent/Guardian Name:				
Email:				
Address:	_____ Street	_____ City	_____ State	_____ Zip Code
Home Phone:		Cell Phone:		

Guardianship information:

Do you have a legal guardian? Yes ☐ No ☐
If yes, please complete:

Guardian Name: _____

Address: _____

Phone Number: _____ Email Address: _____

Work History:

Employer Name:	
Job Duties:	
Dates Employed:	
Paid or non-paid?	
Hours per week:	

Employer Name:	
Job Duties:	
Dates Employed:	
Paid or non-paid?	
Hours per week:	

Did you receive job coaching or other support in previous jobs or volunteering work? Yes ☐ No ☐
If yes, what type?

One-on-one support during my whole shift. ☐

Periodic check ins. ☐

Did you receive any accommodations in a previous job? Yes ☐ No ☐
If yes, what type?

The goal of Project SEARCH is for you to get a job where you:

- Work in an integrated setting. This means you work with people with and without disabilities.
- Are paid the typical wage for this job.
- Work at least 16hrs a week.

Are you willing to work 16 or more hours a week in an integrated setting after you finish Project SEARCH? Yes ☐ No ☐

Where do you think you would like to work after Project SEARCH? _____

Does your family/guardian or support person support your work goals?
Yes ☐ No ☐

Transportation:

Project SEARCH runs 9:00am - 3:00pm, Monday through Friday. As an intern you are responsible for transportation to the host site.

Will you be driving to Project SEARCH? Yes ☐ No ☐
Will you have a family member provide transportation to Project SEARCH daily? Yes ☐ No ☐ If yes, who?
Will you be taking public transportation ie COAST bus or Paratransit? Yes ☐ No ☐
Will your high school be providing transporation? Yes ☐ No ☐
If NO to all of the above, how will you travel to Project SEARCH?

Service Agencies:

Do you have a Vocational Rehabilitation Counselor? Yes ☐ No ☐
If yes, please complete:

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

If no, you can apply here https://nhdoeconsumer.awareportals.com/

Are you receiving services from an area agency? Yes ☐ No ☐
If yes:

☐ One Sky Community Services

☐ Community Partners

☐ Other Area Agency: Name: _____

Have you applied for long term adult services? Yes ☐ No ☐

If yes, which program did you choose? _____

If yes, who is your case manager? _____

Has an agreement been established with your **school district** or **area agency** regarding payment for tuition? Yes ☐ No ☐

Please explain:

Are you currently utilizing services from other agencies? Yes ☐ No ☐
If yes, please complete below:

Agency	Services Provided	Agency Contact	Phone Number	Dates of Service

Why do you want to come to Project SEARCH, and how do you think Project SEARCH will help you achieve your work goals? (To be completed in the applicant's words.)

Applicant and Parent/Guardian please read the applicant agreement below and sign and date.

By applying to Project SEARCH program, you are agreeing to abide by the following terms and conditions:

- I will conduct myself in a mature and professional manner in the Project SEARCH classroom, within Portsmouth Regional Hospital and at the assigned internship sites.
- I will complete at least three unpaid internship rotations within the host business unless offered appropriate employment.
- I will attend the program daily from 9:00am - 3:00pm, Monday through Friday according to the Project SEARCH Seacoast NH calendar and maintain attendance in accordance with program policy – no more than seven absences.
- I will dress appropriately (business casual) and wear required attire when necessary.
- I will notify the Project SEARCH instructor(s) and my internship supervisor when I am absent or tardy.
- I will complete all homework as assigned.
- I understand that I am responsible for transportation to the host site.
- I will learn to use public transportation when available if necessary.
- I will follow all the rules established by the program and hospital.
- I will attend quarterly meetings with my parents/guardians, case manager and SEARCH staff.
- I will be an active participant and communicate any issues or concerns.
- I will actively pursue employment independently as well as with assistance upon graduation.

<u>If accepted and I cannot meet the terms and conditions, I understand I will be asked to leave Project SEARCH.</u>

Applicant Signature	Date
Parent/Guardian Signature	Date

If applicable, the person assisting the student to complete this application is:

Name:	Title:	Date:
Phone Number:	Email Address:	Organization:
Signature:		

Applicant & Guardian Information:

1.**Joint Release:** The student's educational/employment recorded will be transferred from his or her school or agency to Project SEARCH partners (Community Partners, NH Vocational Rehabilitation and Portsmouth Regional Hospital). The health information requested after acceptance is part of this joint release.
2. **Equal Opportunity:** Project SEARCH placement will be made without regard to race, national origin, sex, religion or presence of a disability.
3. **Community Partners:** Policy requires that payment be made prior to the first day of class for each semester. Any school or organization that is paying your first-semester tuition will have to provide a letter to Community Partners committing to that payment.

Applicant Signature	Date
Parent/Guardian Signature	Date

Reference 1 (2 are required)

Please Return to:

Carla Smith
Community Partners
113 Crosby Rd
Dover, NH 03820

Name of Applicant:

_____

Last *First* *M.I*

Program of study: Project SEARCH Seacoast NH

To the Referee:

The above-named applicant is a candidate for admission to Project SEARCH at Portsmouth Regional Hospital. We would appreciate your candid evaluation of the applicant's past performance and potential for success in this program.

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RELATIONSHIP WITH THE APPLICANT:

Employer/Employee Professional/Client Other - Please Describe:

_____

How would describe this person's motivation to gain competitive employment? Do you perceive any potential barriers, and if so, describe?

_____

_____

_____

Circle the appropriate ranking with 1 being Unsatisfactory and 5 being Excellent.

QUALITIES:

WORKS WELL ON A TEAM	1	2	3	4	5
HAS A GOOD MEMORY	1	2	3	4	5
EXHIBITS A POSITIVE ATTITUDE	1	2	3	4	5
STRESS TOLERANCE	1	2	3	4	5
IS SELF-MOTIVATED	1	2	3	4	5
ACCEPTS CONSTRUCTIVE FEEDBACK	1	2	3	4	5
MAINTAINS FOCUS	1	2	3	4	5
IS DEPENDABLE	1	2	3	4	5
FOLLOWS DIRECTIONS	1	2	3	4	5
RESPECTFUL	1	2	3	4	5
INDEPENDENT IN COMMUNITY/WORK SETTING	1	2	3	4	5

SKILLS:

DEMONSTRATES PROBLEM SOLVING SKILLS	1	2	3	4	5
DEMONSTRATES MATURITY	1	2	3	4	5
EXERCISES GOOD JUDGEMENT	1	2	3	4	5
UNDERSTANDS WRITTEN INSTRUCTIONS	1	2	3	4	5
UNDERSTANDS ORAL INSTRUCTIONS	1	2	3	4	5
COMMUNICATES APPROPRIATELY	1	2	3	4	5
IS ACTIVELY INVOLVED IN THE LEARNING/ WORKING PROCESS:	1	2	3	4	5

Name - Please Print _____ Phone _____

Organization and Position_____

Address _____

Signature _____ Date_____

IF AN EMPLOYER OR WORK-BASED LEARNING SUPERVISOR, PLEASE COMPLETE THIS INFORMATION:

Term of applicant's employment: From _____/_____/_____ to _____/_____/_____

Place of employment: _____

Reason for leaving: _____

Would you re-employ? _____ If not, why? _____

_____

Reference 2 (2 are required)

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Community Partners
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Name of Applicant:

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Last *First* *M.I*

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Signature _____ Date _____

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_____

COMMUNITY PARTNERS
DEVELOPMENTAL SERVICES
Release of Information

Client: **DOB**:

Release Authorization
I hereby authorize Community Partners:

- ☐ To send Community Partners records to
- ☐ To receive records from
- ☐ To exchange ongoing verbal information with

With (name of organization, individual or entity):

Address:

Phone: Fax:

Email if sending records electronically:

Reason for Release

- ☐ Care Coordination
- ☐ Discharge Planning
- ☐ Evaluation
- ☐ Other:

Information to be Obtained

- ☐ Assessments
- ☐ Eligibility Determination
- ☐ Medical Records (Physical Exam, History, Medications, Labs, Physician Orders)
- ☐ School Records (IEP, 504, Psychological Testing and Other specified below):
- ☐ Legal Records:
- ☐ Other:

Information to be Released

- ☐ Assessments
- ☐ Service Agreements
- ☐ Behavior/Safety Plans
- ☐ Other:

Authorization to release/obtain information is effective for one year from date of signature unless revoked

Record requests will include previous 2 years of service from the date of request, unless a timeframe is specified below

From: **To:**

Check the box(es) below to exclude drug/alcohol or HIV information for this authorization:

- ☐ Exclude Drug and/or Alcohol Use Information / Treatment
- ☐ Exclude HIV (AIDS) Information

●I understand that there are risks and benefits to sharing the information in my records and agree to share the information described herein to the person/agency named above.

●I understand that I have the right to request to inspect and receive a copy of the information being disclosed through this authorization.

●I understand that information received from another party cannot be re-released by Community Partners without my specific permission.

●I understand that this authorization is subject to revocation at any time by written notice to Community Partners (CP), except to the extent that the agency has already taken action on this authorization (HIPAA) (45 CFR);

●I understand that once the requested information is disclosed pursuant to this authorization, Community Partners will no longer have control over the information, and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (45 CFR);

●I understand that I have the right to decline to sign this authorization and Community Partners will not require me to sign as a condition of treatment, payment, enrollment, or eligibility for benefits (45 CFR);

●I understand that if I decline to sign this authorization form, it could result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences. (45 CFR).

Printed Name	Signature	Date

☐ Client ☐ Parent ☐ Guardian ☐ Other: _____

Client Name: _____ Client DOB: _____