

Sunflower Bakery and Hospitality Employment Training Application 2021-2022

Please provide all information requested, indicating NA where not applicable.

Please let us know if you need an accommodation to complete this application.

APPLICANT INFORMATION

Name: _____ Nickname _____ Gender: M __ F __ NB __

Address _____ City _____ State _____ Zip _____

Email _____

Phone: Day _____ Evening _____ Cell: _____

Date of Birth: _____ Social Security Number: _____

Living Arrangements: (Check one)

With family _____ Spouse _____ Other _____ Alone _____

Legal Guardian(s): _____ Guardian’s Home phone: _____

Work phone: _____ Cell: _____ E-mail: _____

Sunflower only accepts students who are planning to seek employment after training. Do you have permission to work in the United States? _____ If accepted for training, then documentation must be presented at that time. To review acceptable documentation, please go to <http://www.uscis.gov/files/form/i-9.pdf>, scroll to the 5th page and read, “Lists of Acceptable Documents,” to ensure you have the correct ones.

I understand that it is Sunflower Bakery’s policy that ALL APPLICANTS MUST BE FULLY VACCINATED FOR COVID-19, or be exempt for religious or medical reasons, in which case they must show proof of a negative COVID test within 48 hours of interviewing, participating in Assessments, or beginning a class. _____ (Please initial here.)

EDUCATION Please list education in chronological order, including high school attended, post-secondary school or college and all dates. Indicate if you graduated with a certificate/diploma/degree and the date.

Name of school _____ Dates _____ Certificate/diploma/degree? _____

TRAINING & EMPLOYMENT Please list training programs and employment in chronological order. Use back of page if necessary. **Attach resume if you have one.**

Name of employer or training program Dates Contact Name Contact Number

BAKING EXPERIENCE Have you had any experience cooking or baking, either on a job or at home? Yes __ No

Have you had any experience working in customer service, food service, or a retail environment? __ Yes __ No

Do you have a genuine interest in training for a job in the food or hospitality industry? Yes __ No

If **yes** to above, please do a little self-assessment of what you have tried from the list below. Please rate for each skill:

Can do independently = I Need help = NH Not successful even with help = NS

Identify ingredients ____

Identify utensils ____

Wash dishes ____

Clean tables ____

Mop floors ____

Sweep floors ____

Measure with measuring cups ____

Use measuring spoons ____

Use sharp knives ____

Understand need to wash hands ____

Use whisk ____

Use rubber spatula ____

Can lift and carry 50 pounds ____

Turn oven off/on ____

Use microwave ____

Use electric hand mixer ____

Use food processor ____

Use rubber gloves ____

Use electric stand mixer ____

Tie/secure apron ____

Remove hot pans from oven ____

Make coffee or tea ____

Take customer orders ____

Bag or box purchases ____

Wrap food in plastic wrap ____

Restock products ____

Empty trash in dumpster ____

Use cash register/other point of sales equipment ____ Answer questions about products ____

Count change in bills and coins ____

Name of Applicant _____

Please indicate if you are able to do the following things, with or without reasonable accommodation:

Read at or about the 4th grade level ___Yes ___No Calculate basic math at 4th grade level ___Yes ___No

Stand for 4 hours while working ___Yes ___No

Answering the following question is voluntary. If you decline to do so, it will not affect consideration for the program.

Our mission is to prepare adults 18 and over with learning differences, who would benefit from skilled training for employment in baking, hospitality, or other related industries. Do you have learning differences? ___Yes ___No

Additional Information

Please check appropriate spaces that apply to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Limited mobility |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Speech/language impairment | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mild intellectual disability | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Moderate intellectual disability | <input type="checkbox"/> Attention deficit hyperactivity disorder | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Epilepsy/seizure disorder | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Limited vision |
| <input type="checkbox"/> Psychiatric diagnosis/ mental illness* | <input type="checkbox"/> TBI | <input type="checkbox"/> Chronic medical condition |

Are you currently taking any medications for any of the above? ___yes ___no

If yes, which medications? _____

***Psychiatric Diagnosis**

Primary Diagnosis _____

Additional Diagnoses _____

Please attach a copy of the most recent psychological evaluation results or IEP.

Please comment on any of the above with regard to educational, training or work settings. Please indicate any restrictions from participation in Bakery activities. Use back of page if necessary.

BEHAVIORAL CONCERNS

Do you (check if yes):

- | | |
|--|--|
| Threaten to do physical violence _____ | Ignore or resist following instruction or routines _____ |
| Damage personal property _____ | Lie or steal _____ |
| Damage the property of others _____ | Abuse self _____ |
| Damage public property _____ | Abuse substances _____ |
| Use angry language _____ | Have socially unacceptable sexual habits _____ |
| Have violent temper or temper tantrums _____ | Exhibit offensive behavior with peers _____ |
| Have difficulty with authority figures _____ | Have a record of any arrests _____ |

Please comment on any of above with regard to educational, training or work settings:

Sunflower Bakery has a zero tolerance policy for violence, threats of violence, damage to property, stealing, substance abuse, etc. A criminal background check may be required.

Name of Applicant _____

Sunflower Bakery - Other Releases

I hereby give permission to the professionals listed below to release information that would relate to my training/employment with the Sunflower Bakery. This would include diagnoses, treatment summaries, test results, behavior management programs, verbal exchanges between treating persons or facilities, and any other information or recommendations considered pertinent to this relationship.

_____ Date: _____ (today) through _____ (18 mos. from application date)

Relationship to applicant _____

Signature of applicant/custodial parent/guardian: _____

REFERENCES

Please provide information below for at least **one professional contact** from any previous employment or vocational training/day/school programs, who may be used as a reference. Please provide a copy of most recent IEP from high school if you have one. Please provide information below for **one contact person from any current or previous DDA or DORS service provider** who may be used as a reference. Please list any **therapists** with whom the applicant may be currently involved.

Name/ Title/ Agency/ Address/ Phone/ E-mail

Any additional information you would like to share?

HOW DID YOU FIND OUT ABOUT SUNFLOWER BAKERY? _____

HAVE YOU MET WITH ANYONE FROM THE MD DIVISION OF REHABILITATION SERVICES (DORS)? ____ YES ___ NO

IF IN VIRGINIA, Department of Aging and Rehabilitative Services? ____ YES ____ NO

IF IN DC, Rehabilitation Services Administration? ____ YES ____ NO

DO YOU HAVE A DORS OR OTHER COUNSELOR FROM ONE OF THE ABOVE REHABILITATION SERVICES? ____ YES ____ NO
IF SO, WHO AND AT WHICH OFFICE?

HEALTH AND MEDICAL INFORMATION

Name of Applicant _____ Primary Physician: _____

Telephone number: _____ FAX: _____

Name of Psychiatrist/Therapist/Counselor (if applicable): _____

Telephone number _____

ALLERGIES: _____

Name of Dentist: _____ Telephone number: _____

Medical insurance covered by (name of company) _____

Group: _____ Governmental Program: _____

Policy number: _____ Medical concerns _____

EMERGENCY CONTACTS

Emergency contact #1 Name: _____ Relationship: _____

Day phone: _____ Cell phone: _____ e-mail _____

Emergency contact #2 Name: _____ Relationship: _____

Day phone: _____ Cell phone: _____ e-mail _____

Emergency contact #3 Name: _____ Relationship: _____

Day phone: _____ Cell phone: _____ e-mail _____

Medical Release

I/ the applicant have/s permission to participate in all Sunflower Bakery activities except as noted by me. I give permission to the physician selected by Sunflower Bakery to order x-rays, routine tests, and treatment related to my health/the health of the participant for emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for me/this applicant. I understand the information on this form will be shared on a "need to know" basis with Bakery staff. I give permission to photocopy this form. In addition, the Sunflower Bakery has permission to obtain a copy of the applicant's health record from providers who treat him/her and these providers may talk with the Bakery's staff about the applicant's health status.

_____ Date: _____ through _____ Relationship to applicant _____

Signature of applicant/cust. parent/guardian today (18 months from application date)

ADDITIONAL PROGRAM REQUIREMENTS

SUPPORT PERSON

Each applicant must have a support person/agency whether a family member, friend, social worker, service provider or other person/entity who will be available to provide support throughout the training and employment. Please provide name(s) and relationship.

Name _____ Relationship _____

Name of Applicant _____

How would you see this person involved? (please check all that apply)

___ Attend a meeting with you before you would begin the program to discuss the program and expectations.

___ Someone to help you resolve concerns, problems, barriers that may be preventing your full participation.

___ Receive copies of evaluations.

___ Be available to you to help review material or practice skills being learned.

___ Person will sign Support Agreement upon applicant's acceptance for training.

Name of Applicant _____

Next steps: after we review your application, we will contact you regarding an interview. The interview includes a meeting to share and gather information. You will be expected to provide information about your education, your work and training experiences and your interest in baking and/or hospitality. You will complete a brief basic math quiz and you may spend some time in the kitchen with a chef, as well. You may also be asked to return to do a 3-day hands-on Kitchen Assessment or a 2-day Hospitality Assessment.

Fees: Sunflower Bakery works with all appropriate candidates to ensure their ability to participate in our program.

The cost of the program is satisfied through Maryland's Division of Rehabilitation Services (DORS), RSA in DC and/or private pay. Private pay includes individual/family participation and/or generous needs-based funding available through Sunflower Bakery. You may also be eligible for funding through a service provider or another agency. Program costs include a \$500 Kitchen Assessment Fee or \$250 Hospitality Assessment Fee, plus a fee for supplies and equipment, as well as the costs of instruction and job search guidance during the 26-week program. Hospitality students may be paid, if they qualify, during the 8-week internship.

PLEASE RETURN THIS APPLICATION TO:

SUNFLOWER BAKERY

ATTENTION: SARA PORTMAN MILNER, LCSW-C

5951 Halpine Road, Rockville, MD 20851

OR E-MAIL to

programs@sunflowerbakery.org

Thank you for completing this application.