598 Broadway, 7th Floor | New York, NY 10012 | t: 212.274.0550 | f: 212.274.0886

REFERRAL PACKAGE

Project Comeback is ACE's job-readiness training program for men and women with a history of homelessness. In order to be eligible for the program, the applicant must meet the following criteria:

1. Housing: All applicants must have a history of homelessness.
   - Applicant is living in a transitional therapeutic community for substance abuse rehabilitation; or
   - Applicant is living in transitional or supportive housing for homeless persons who originally came from the streets or emergency shelter; or
   - Applicant is living with friends, family, etc. and is referred by and attending a therapeutic community for substance abuse rehabilitation; or
   - Applicant is living in a shelter that provides case management.
2. Sobriety: Project Comeback is a clean and sober program.
   - Applicants must have a minimum of 30 days sobriety; and
   - If applicant has any history of substance abuse, s/he must be in either an inpatient or outpatient treatment program for the duration of Project Comeback.
3. Criminal History
   - Applicant CANNOT have any violent or aggressive criminal history (e.g. rape, manslaughter, pedophilia, or any crime involving a weapon); and
   - Referral source must provide a detailed list of criminal history including the client's present parole officer's name and phone number.
   - All applicants are evaluated on an individual basis
4. Medical Form and Psychiatric History
   - Due to the moderate to heavy lifting and walking/standing over a 4-hour shift, Project Comeback will only accept the medical clearance and TB (PPD) form provided in the referral package (page 5); and
   - Applicants to the program on medication for an Axis 1 diagnosis must have six months documented stability on the medication; and cannot have had an inpatient psychiatric hospitalization in the last six months.
5. Client must be at least 21 years old.
6. **Client must be a Legal U.S. Resident. At time of intake, please send the client with identification i.e., N.Y. State issued ID, Benefits Card, Social Security Card, Birth Certificate, etc.**

If you have any questions about Project Comeback or these requirements, please call the Coordinator of Vocational Rehabilitation Services at 212.274.0550 Ext. 18 or the Education Coordinator at Ext. 58.

Referral Procedures

1. **You must complete the entire referral package in order to be considered.**

2. Fax completed referral package **(pages 3-5)** to (212) 274-0886 or email to ovanosch@acenewyork.org.

3. Upon receipt, referral will be reviewed and a background check will be conducted.

4. If the client meets the program criteria, the Project Comeback Education Coordinator will be in touch with you to schedule an intake date.

5. Following intake, accepted clients will be assigned a 3-week trial period. During this trial period, Project Comeback staff will assess client motivation and willingness to fulfill assigned pre-vocational goals. Clients who successfully complete the trial period will be accepted into Project Comeback. Once in Project Comeback, clients will receive a weekly stipend for vocational training.

6. Clients are responsible for notifying their referring case managers of their Project Comeback start date and assigned schedule.

Once a client is accepted into the program, the referring Case Manager is responsible for:

1. Maintaining contact with the client's Project Comeback Case Manager to follow up on client progress, as well as provide updates on client housing and treatment status.

2. Informing potential clients that Project Comeback is a job readiness/training program, not a placement agency, and that clients are responsible for conducting an independent job search with assistance from our staff.

3. Providing support to clients on personal, vocational, and educational issues, including referrals to outside agencies when appropriate.

4. Meeting with clients on a monthly basis to review their progress in Project Comeback.

Referral Form

Applicant Name: _____ Application Date: _____

Alias: _____ Date of Birth: _____

Applicant Address: _____
Street *City* *State* *Zip*

Date Applicant Entered Referring Program / Residence: _____

Applicant's Expected Move Out Date from Program / Residence: _____

Referred by: _____
Name *Organization*

Psychiatric History

Does the applicant have any mental health conditions? O Yes O No
If YES, please list: _____

Is the applicant currently taking any medications? O Yes O No
If YES, please list: _____

Sobriety: Project Comeback is a Clean and Sober Program

This applicant is considered to be clean and sober since: _____(date)

Is the applicant in treatment for substance abuse? O Yes O No
Notes: _____

Criminal History

Does the applicant have any criminal history? O Yes O No
If YES, list and describe all. (Use additional pages as necessary.)

_____

_____

_____

Has applicant ever been convicted of a violent or aggressive crime? O Yes O No

Is applicant on Parole/Probation? O Yes O No
If YES, list PO name and phone number: _____

Applicant's most recent police contact: _____ (date)

Release of Information Form

I authorize **(*NAME OF AGENCY* to release information)** _____ to release my clinical information (psychiatric / medical / rehabilitation / social service / education / criminal history / drug and alcohol test results) to the program staff of **Project Comeback**. I understand that this information is used only to arrange services for me; is confidential; and is protected from disclosure. The extent or nature of information to be released is restricted to the following:

I also authorize staff at **Project Comeback** to share this information with the aforementioned agency and the agency(s) listed below if / when I am referred to the agency(s) for service. These agencies may include; Project Renewal, C.S.S., Dress for Success, Career Gear, Legal Action Center, and any other agencies listed below. I understand that the agency(s) will maintain the confidentiality of this information and will not release it to any other agency or individual without my signed consent:

1. 2.

3. 4.

I understand that I have the right to cancel my permission to release information any time before it is released. I also understand that this consent to release information will expire when acted upon or 180 days from this date, whichever occurs first.

Client signature Print name Date

Referral counselor signature Print name Agency Date

TB (PPD) Clearance & Work Clearance

Client's Name: _____

_____

We understand that the above-mentioned client has seen you in your capacity as a doctor. Before we can process his/her application, we need a doctor's clearance regarding his/her capacity to work as well as his/her Tuberculin Skin test or Chest X-ray. Should you have any questions regarding the above request, please feel free to call me 212-274-0550 x67. Thank you!
Elizabeth McNierney, Program Director

Please complete the necessary information and return with client.

TB (PPD) Clearance

Mr./Ms. (client's name): _____ was seen by me on

(date): _____ at (facility): _____

Client has received _____PPD (strength):_____ on

Rt. forearm _____ Lt. forearm _____

Please return on (date): _____ so that test results can be

read and recorded.

Given by _____ (CLR): _____ (date): _____

****Results** (positive):_____(negative):_____

(treatment): _____

Work Clearance

Mr./Ms. (client's name): _____was seen by me

on (date): _____ at (facility): _____

He/she is in good physical condition and is able to participate in work related duties, without restrictions, that includes moderate to heavy lifting and walking/ standing on his/her feet over a 4-8 hour time span.

(Doctor's signature): _____ (NYC LIC#): _____

(Please Print Name): _____ (Date): _____