|  |  |  |  |
| --- | --- | --- | --- |
| **HEALTH AND EMPLOYMENT COUNSELING (HEC) APPLICATION** | | | |
| You must complete this form to enroll in the Health and Employment Counseling (HEC) program. The HEC program is for people who are applying for or are enrolled in the Medicaid Purchase Plan (MAPP) and are not currently meeting the work requirement. The HEC program can help people stay in MAPP while working toward employment.  For help completing this application, refer to the Health and Employment Counseling Consumer Guide, available at [dhs.wi.gov/library/collection/P-20220A](https://www.dhs.wisconsin.gov/library/collection/P-20220A).  Any personal information collected here will be used to establish your enrollment in HEC. This application is also your employment plan. Keep a completed copy of this application for your records so you can follow your employment plan. You can also contact the HEC coordinator to have a completed copy mailed to you.  Once you submit this completed form, a decision will be made in 10 business days, and we will send you an approval or denial letter.  If you have questions about this application or the HEC program, contact the HEC Program Coordinator by phone at 866-278-6440 or email at [DHSHECMailbox@dhs.wisconsin.gov](mailto:DHSHECMailbox@dhs.wisconsin.gov). | | | |
|  | | | |
| SECTION 1: APPLICANT INFORMATION (Please print) | | | |
| Name – Applicant | | Date of Birth | Case Number (if any) |
| Mailing Address | | City | ZIP Code |
| County of Residence | | Phone Number | |
| **Contact information of the person** **helping you fill out this application (if any)** | | | |
| Agency, if applicable | Name | Job Title, if applicable | Phone Number |
| Mailing Address | | City | ZIP Code |
|  | |  |  |
| SECTION 2: EMPLOYMENT PLANNING | | | |
| I am working with the Division of Vocational Rehabilitation (DVR) part of the Department of Workforce Development and have attached my completed and signed employment plan. Go to Section 3.  I am working with the FoodShare Employment and Training (FSET) program and have attached my completed and signed employment plan. Go to Section 3.  If you **do not** have an active employment plan from DVR or FSET you must complete the rest of Section 2. | | | |
| **Employment**—List any job, self-employment, or work that is paid in goods or services that you might like to have in the next nine months. Be as specific as possible. Examples are stocker, laborer, office assistant, cashier, welder, or teacher. Do not include volunteer commitments or volunteer interests, as this does not meet the work requirement for MAPP. **Rank jobs from 1 to 3, with 1 being your first choice.** | | | |
| 1. 1. | | | |
| 1. 2. | | | |
| 1. 3. | | | |

|  |  |  |
| --- | --- | --- |
| **Skills and Personality**—What skills and personality traits do you have that make these jobs good choices for you? Examples may include good attitude, people person, good listener, willing to take on responsibility, good at asking questions, or good with numbers. | | |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| **Skills Development**—What skills do you need to work on to help you reach employment in the job(s) you listed above? | | |
| **Skill** | **Steps to Develop Skill** | |
| 1. |  | |
| 2. |  | |
| 3. |  | |
| **Employment Barriers**—Think about your job goals. What is stopping you from going to work now? Examples of barriers may include transportation, equipment, lack of education or skills, or needing work breaks because of your disability.  Writing down these barriers will help you think about how you can overcome them. If you have ideas on how to begin to remove barriers to work, you can list them here. Keep in mind these may change as you find and start a job. You may need to look at this list again and write down different barriers. | | |
| **Employment Barrier** | **Steps to Remove Barrier** | |
| 1. 1. |  | |
| 1. 2. |  | |
| 1. 3. |  | |
| 1. 4. |  | |
| 1. 5. |  | |
| **Barriers Resources**—Do you know people or agencies that can help you overcome your employment barriers? This will help you track your contacts. The HEC program will not contact anyone listed in this section. | | |
| **Name** | **Role** | **Phone Number** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

|  |  |  |
| --- | --- | --- |
| **Networking with Existing Community Resources**—What organizations, if any, have you already met with to discuss your employment goals and plans to develop your skills and overcome employment barriers?  This section is to help you track your contacts. The HEC program will not contact anyone listed in this section. | | |
| **Organization** | | **Date** |
| 1. | |  |
| 2. | |  |
| 3. | |  |
| 4. | |  |
| 5. | |  |
| What organizations, if any, do you plan to contact to address any additional employment barriers, and when do you plan to contact them? | | |
| 1. | |  |
| 2. | |  |
| 3. | |  |
| 4. | |  |
| 5. | |  |
| **Create a Plan**—Take your **number one job from above** and list the steps needed to get it. Also, list when you plan to take these steps and who can assist you. Keep in mind these steps may change as you gather information. | | |
| **Steps Needed** | **When?** | **Who Can Help~~?~~** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |

|  |
| --- |
| SECTION 3: APPLICANT RESPONSIBILITIES |
| I understand that when I start working I must report my employment to my local agency and to the Health and Employment Counseling program coordinator. |
| **Agreement to Complete Employment Plan**  I understand that by signing this application, I agree to complete the goals, actions, steps, and activities I have listed in this plan. |

|  |  |
| --- | --- |
| SECTION 4: SIGNATURE | |
| **Printed Name** – Applicant | |
| **Signature** – Applicant | **Date Signed** |
| **Signature** - Person who helped with this form (if any) | **Date Signed** |
|  |  |
| DISCLAIMER | |
| Whenever a person with a disability considers employment, it is important to understand how work may affect public and private benefits. Participation in the HEC program for MAPP may increase your income which could result in a change to your other benefits. It is up to you to learn and understand how employment and increased income may impact your benefits, and to make an informed choice about pursuing employment. Further, by participating in the HEC program, the Department of Health Services makes no guarantee that you will have a job at the end of the 9-month period. Many factors may affect your success in finding employment including job environment, career goals, transportation availability, etc. | |
|  | |
| SUBMIT YOUR APPLICATION | |
| Submit your completed and signed application one of these ways. | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Smart Phone with solid fill** | **Mobile App** | **Envelope with solid fill** | **Mail** | |
| Take a photo of all the pages of the form and submit them using the MyACCESS mobile app. | | * If you live in **Milwaukee County**:   MDPU  6055 N. 64th St.  Milwaukee, WI 53218   * If you do **not** live in Milwaukee County:   CDPU  PO Box 5234  Janesville, WI 53547 | |
| **Laptop with solid fill** | **Online** |
| Scan all pages of the form to the ACCESS website. You can do this through your ACCESS account, which you can log into at [access.wi.gov](https://access.wisconsin.gov/). | |
| **Printer with solid fill** | **Fax** | **User with solid fill** | **In Person** | |
| * If you live in **Milwaukee County**, fax the form to 888-409-1979. * If you do **not** live in Milwaukee County, fax the form to 855-293-1822. | | Take the form to your agency. Find your agency contact at [dhs.wi.gov/im-agency](https://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm). | |