



DIVISION OF VOCATIONAL REHABILITATION (DVR)

Vocational Information

FOR DVR STAFF ONLY
VRC ASSIGNED
APPLICATION DATE

Please complete as much of this form as you can. This information will assist the Division of Vocational Rehabilitation (DVR) in determining your eligibility and vocational planning. Your information will be kept confidential and only used as necessary for your rehabilitation. If you need help filling out this form, ask your counselor for assistance.

I. Personal Information

1. SOCIAL SECURITY NUMBER	2. APPLICANT'S FIRST NAME	MIDDLE INITIAL	LAST NAME
3. PREFERRED TO BE CALLED (NAME)	4. PREVIOUS LAST NAME	5. PREVIOUS FIRST NAME	
6. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	7. BIRTHDATE	8. COUNTY IN WHICH YOU LIVE	
9. MAILING ADDRESS	CITY	STATE	ZIP CODE
10. STREET ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)	CITY	STATE	ZIP CODE
11. E-MAIL ADDRESS	12. VIDEOPHONE IP		
13. TELEPHONE NUMBER (INCLUDE AREA CODE) <input type="checkbox"/> CELL <input type="checkbox"/> TTY/TDD	14. TELEPHONE NUMBER (INCLUDE AREA CODE) <input type="checkbox"/> CELL <input type="checkbox"/> TTY/TDD		
15. MARITAL STATUS <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Widowed			
16. ARE YOU A U.S. CITIZEN? <input type="checkbox"/> Yes <input type="checkbox"/> No If not a U.S. citizen, do you have a valid work permit (green card)? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a valid work permit? <input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, date of expiration: _____			

17. Number of dependents: _____ Number in family: _____

18. HOUSEHOLD MEMBER NAMES	RELATIONSHIP	AGE	HOUSEHOLD MEMBER NAMES	RELATIONSHIP	AGE

19. LIVING ARRANGEMENT

<input type="checkbox"/> Private residence	<input type="checkbox"/> Adult correctional facility
<input type="checkbox"/> Community residential / group home	<input type="checkbox"/> Halfway house
<input type="checkbox"/> Rehabilitation facility	<input type="checkbox"/> Substance abuse treatment center
<input type="checkbox"/> Mental health facility	<input type="checkbox"/> Homeless / shelter
<input type="checkbox"/> Nursing home	<input type="checkbox"/> Other: _____

20. LEGAL ISSUES

Do you have a criminal history that affects whether you can work in certain jobs or fields? Yes No

Do you have a DWI/DUI conviction? Yes No

Have you been convicted of a felony? Yes No If yes, give the information below:

Probations/Parole Officer's Name: _____ Telephone Number: _____

Release Date: _____ City/Jurisdiction: _____

II. Medical / Psychological

1. Do you have one or more conditions which affect your ability to work? Yes No

2. Is your condition:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Alcohol/drugs | <input type="checkbox"/> Psychiatric/emotional |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Sensory (hear/see) | <input type="checkbox"/> Learning disability |

3. Briefly describe the condition(s):

4. Are you taking medications? Yes No If yes, please list:

5. How does your condition(s) prevent you from getting a job, keeping a job, or performing essential job duties?

6. Do you have problems or concerns about the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech | <input type="checkbox"/> Bowels |
| <input type="checkbox"/> Head injury or stroke | <input type="checkbox"/> Tumor / cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blackouts / fainting |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Seizures / convulsions | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Asthma / shortness of breath | <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies / rashes | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Stomach, intestines | <input type="checkbox"/> Mobility | | |

7. Have you ever been unconscious? Yes No If yes, explain briefly:

8. Describe other health problems:

9. Do you have problems or concerns about the following?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Stamina / strength | <input type="checkbox"/> Depression | <input type="checkbox"/> Remembering things | <input type="checkbox"/> Anger or short temper |
| <input type="checkbox"/> Following instructions | <input type="checkbox"/> Reading or writing | <input type="checkbox"/> Stress | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Getting along with others | <input type="checkbox"/> Coordination | <input type="checkbox"/> Working slowly | <input type="checkbox"/> Math |
| <input type="checkbox"/> Absent from work a lot | <input type="checkbox"/> Speech | <input type="checkbox"/> Anxiety or panic | |

10. Have you ever received treatment for:

a. Emotional or mental health problem? Yes No If yes, please explain:

b. Drug and/or alcohol dependency? Yes No If yes, please explain:

11. List the physicians or specialists involved in the treatment of your condition(s).

DATES OF TREATMENT	NAME	ADDRESS

12. Have you ever been hospitalized for your condition(s)? Yes No

DATES OF TREATMENT	HOSPITAL	ADDRESS

REASON

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REASON

III. Education and Work Study

1. Are you in high school or in a transition program? Yes No If yes, please answer the following:

Do you have a 504 accommodation plan? Yes No

Are you receiving services under an IEP? Yes No

2. Did you complete high school? Yes No Did you get a diploma or GED? Yes No

SCHOOL NAME	YEAR COMPLETED	CITY AND STATE	IF NO, WHAT GRADE DID YOU LAST ATTEND?

3. Have you gone to college? Yes No

COLLEGE/UNIVERSITY	NUMBER OF YEARS ATTENDED	YEAR COMPLETED	MAJOR AREA(S) OF STUDY	DEGREES

List schools or training:	List special skills, certificates or licenses:
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4. MILITARY SERVICE

Have you served in the military? Yes No Discharge type: _____

If yes, list branch of service: _____ Dates of service: _____

List job titles, skills and special training:

5. What is your current employment status?

<input type="checkbox"/> Employed full or part time	<input type="checkbox"/> Employment with supported employment services
<input type="checkbox"/> Extended Employment (a sheltered workshop)	<input type="checkbox"/> Not employed, attending college
<input type="checkbox"/> Self-Employment	<input type="checkbox"/> Not employed, attending high school or GED program
<input type="checkbox"/> State Agency-Managed Business Enterprise Program (BEP)	<input type="checkbox"/> Not employed, attending trainee, intern or volunteer
<input type="checkbox"/> Unpaid family worker (family business or farm)	<input type="checkbox"/> Not employed, other
<input type="checkbox"/> Homemaker (care for home so another person in the household can earn income)	

Work History: List your past three (3) jobs

JOB TITLE	START DATE	END DATE
EMPLOYER	CITY AND STATE	
Salary: \$ _____ per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-week <input type="checkbox"/> Month <input type="checkbox"/> Annual		NUMBER OF HOURS WORKED PER WEEK
SKILLS/DUTIES	REASON FOR LEAVING	

JOB TITLE	START DATE	END DATE
EMPLOYER	CITY AND STATE	
Salary: \$ _____ per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-week <input type="checkbox"/> Month <input type="checkbox"/> Annual		NUMBER OF HOURS WORKED PER WEEK
SKILLS/DUTIES	REASON FOR LEAVING	

JOB TITLE	START DATE	END DATE
EMPLOYER	CITY AND STATE	
Salary: \$ _____ per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-week <input type="checkbox"/> Month <input type="checkbox"/> Annual		NUMBER OF HOURS WORKED PER WEEK
SKILLS/DUTIES	REASON FOR LEAVING	

Were assistive devices or reasonable accommodations needed, provided or attempted on any job?
 If yes, please explain:

IV. Contact Information

1. If we are unable to reach you whom should we contact?

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP

2. PARENT OR LEGAL GUARDIAN

Are you a minor (under the age of 18) or do you have a court appointed legal guardian? Yes No
 If yes, please provide contact information for your parent or legal guardian:

NAME	TELEPHONE NUMBER	E-MAIL ADDRESS

MAILING ADDRESS	CITY	STATE	ZIP CODE

THIS BOX TO BE COMPLETED BY DVR STAFF

If individual has a legal guardian, has DVR obtained a copy of the legal guardianship signed by a judge?
 Yes No

V. Race and Ethnicity

Providing this information is not necessary to receive DVR services. The federal government requires that race / ethnicity information be kept for data purposes only. If you choose not to disclose this information, DVR is required to specify your race / ethnicity.

All agencies that receive federal funds must report race/ethnicity data either by a customer's self-report or by staff observations. This is based on the federal Office of Management and Budget (OMB) Statistical Policy Directive Number 15, Race and Ethnicity Standards for Federal Statistics and Administrative Reporting.

Ethnicity

- Not Hispanic / Latino
- Hispanic / Latino

If yes, please check the appropriate box(es) below:

- Mexican American Puerto Rican
- Cuban Other (specify): _____

Race

Please check the appropriate box(es) below regarding your race / ethnicity.

- American Indian / Alaska Native Cambodian Hawaiian Thai
- List Tribe: _____ Chinese Japanese Vietnamese
- Black / African American Filipino Laotian White / European American
- Guamanian Samoan Other (specify): _____

VI. Communications and Transportation Needs

What languages do you speak, read, and/or write fluently?

Do you have reliable transportation available? Yes No

DRIVER'S LICENSE NUMBER

THIS BOX TO BE COMPLETED BY DVR STAFF

Communication ability:

Transportation use ability:

VII. Financial Support and Medical Insurance

1. If you are not working, how do you support yourself?

2. Do you receive support from any of the following agencies?

- None
- Social Security Disability Insurance (SSDI) \$ _____
- Supplemental Security Income (SSI) for the Aged, Blind or Disabled \$ _____
- Temporary Assistance for Needy Families (TANF) \$ _____
- General Assistance (State or local government) \$ _____
- Veteran's Disability Benefits \$ _____
- Worker's Compensation \$ _____
- Employment Security (Unemployment Insurance) \$ _____
- All other public support \$ _____

3. How much is your TOTAL monthly income from all sources and/or benefits? \$ _____

4. When you go to work, how much will you need to earn per month to support yourself and/or your family? \$ _____

5. Do you have medical insurance? Yes No

- Medicaid Medicare
- Public insurance from other sources (Worker's Compensation, Children's Health Insurance Program, etc.)
- Private insurance through own employer
- Private insurance through other source
- Not yet eligible for private insurance through current employer, but will be eligible after a certain period of time.

VIII. Vocational Rehabilitation Involvement

1. Are you involved with any of the following agencies or programs?

- Not provided services or funding from any programs or organizations listed below.
- Alcohol/drug treatment
- American Indian VR Services Program
- Centers for Independent Living
- Child Protective Services
- Community Rehabilitation Programs
- Consumer Organizations or Advocacy Groups
- Educational Institutions (Elementary/High School)
- Educational Institutions (Post-Secondary/College)
- Employers
- Employment Networks
- Federal Student Aid (such as, Pell Grants, etc.)
- Intellectual and Developmental Disabilities Agencies
- Medical Health Provider (Public or Private)
- Mental Health Provider (Public or Private)
- One-Stop Employment Training Centers (WorkSource)
- Public Housing Authority
- Social Security Administration (SSA)
- State Department of Corrections/Juvenile Justice
- State Employment Security Agency (Employment Security)
- Veteran's Administration
- Welfare Agency (State or local government) (DSHS)
- Worker's Compensation (L&I)
- Other VR State Agencies
- Other State Agencies
- Other Services

2. Who referred you to DVR? If you were not referred, select Self-referral.

- Educational Institutions (high school)
- Educational Institutions (college)
- Medical Health Provider
- Welfare Agency (state or local) (DSHS)
- Community Rehabilitation Programs
- Social Security Administration
- One-stop Employment Training Centers (WorkSource)
- Self-Referral
- Other Sources
- American Indian VR Services Program
- Centers for Independent Living
- Child Protective Services
- Employers
- Faith Based Organizations
- Family/Friends
- Intellectual and Developmental Disabilities Providers
- Mental Health Provider (Public or Private)
- Public Housing Authority
- State Department of Correction/Juvenile Justice
- State Employment Service Agency (Empl. Security)
- Veteran's Administration
- Worker's Compensation (L&I)
- Other State Agencies
- Other VR State Agencies
- Consumer Organizations or Advocacy Groups

3. HAVE YOU BEEN INVOLVED WITH DVR BEFORE? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHEN	WHERE
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VOCATIONAL REHABILITATION COUNSELOR'S NAME	YOUR NAME (IF DIFFERENT THEN)
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4. What do you want from DVR?

5. What are your immediate job interests?

6. If you are not working, what have you been doing to prepare for or find a job?

7. Do you have any job prospects right now? Yes No

8. What are your long-range career goals?