



Application for Vocational Rehabilitation Services

| Applicant Information | | | |
|--|---|---|---|
| 1. APPLICANT'S FIRST NAME | MIDDLE INITIAL | LAST NAME | 2. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other: <input type="checkbox"/> Chooses not to identify |
| 3. BIRTH DATE | 4. SOCIAL SECURITY NUMBER | | |
| Contact Information | | | |
| 5. TELEPHONE NUMBER (INCLUDE AREA CODE) | | 6. EMAIL ADDRESS | |
| 7. VIDEOPHONE IP | | 8. COUNTY | |
| 9. STREET ADDRESS | | CITY | STATE |
| 10. PREFERRED COMMUNICATION <input type="checkbox"/> Email <input type="checkbox"/> Telephone <input type="checkbox"/> Mail <input type="checkbox"/> Other: | | 11. LANGUAGE ACCESS ACCOMMODATION? <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Preferred Language: | |
| Student and Disability Information | | | |
| 12. Enrolled in a recognized educational program, including, but not limited to: High-School, Vocational or Technical School, Community, or Technical College: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Student with a disability: | | | |
| <input type="checkbox"/> 0. Individual is not a student with a disability | | | |
| <input type="checkbox"/> 1. Student with a disability and receiving 504 accommodation | | | |
| <input type="checkbox"/> 2. Student with a disability and receiving transition services under an IEP | | | |
| <input type="checkbox"/> 3. Student with a disability, no 504 accommodation, and not receiving transition services under an IEP. | | | |
| Individual with a disability: | | | |
| <input type="checkbox"/> 1. Individual reports that he / she has any disability, as defined in the Americans with Disabilities Act | | | |
| <input type="checkbox"/> 0. Individual reports that he / she does not have a disability that meets the definition | | | |
| <input type="checkbox"/> 9. Individual did not self-identify | | | |
| Race and Ethnicity Information | | | |
| 13. RACE AND ETHNICITY | | | |
| Providing this information is not necessary to receive DVR services. The federal government requires that VR agencies maintain race / ethnicity information for data purposes only. If you choose not to disclose this information, DVR must 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. | | | |
| The federal Office of Management and Budget (OMB) Statistical Policy Directive No. 15, "Race and Ethnicity Standards for Federal Statistics and Administrative Reporting," is the basis for the options below. | | | |
| Ethnicity: | | | |
| If Hispanic / Latino, please check the appropriate box(es) below: | | | |
| <input type="checkbox"/> Not Hispanic / Latino | <input type="checkbox"/> Mexican American | <input type="checkbox"/> Puerto Rican | |
| <input type="checkbox"/> Hispanic / Latino | <input type="checkbox"/> Cuban | <input type="checkbox"/> Chicano | |
| <input type="checkbox"/> Did not self-identify | <input type="checkbox"/> Other (please specify): | | |
| Race: | | | |
| Please check the appropriate box(es) below regarding your race / ethnicity. | | | |
| <input type="checkbox"/> American Indian / Alaska Native; if checked, please list Tribe / Community Attachment: | | | |
| <input type="checkbox"/> Black / African American | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Indian (Southeast Asian) | <input type="checkbox"/> Korean | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Thai | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Japanese | <input type="checkbox"/> White / European American |
| <input type="checkbox"/> Other Asian or Pacific Islander (please specify): | | | |
| <input type="checkbox"/> Other (please specify): | | | |
| <input type="checkbox"/> Do not wish to disclose | | <input type="checkbox"/> Not reported | |

Referral Information

14. Who referred you to DVR? If you were not referred, please select "Self Referral."

- | | |
|---|---|
| <input type="checkbox"/> Self Referral | <input type="checkbox"/> Juvenile Rehabilitation Youth |
| <input type="checkbox"/> 14(c) Certificate Holder | <input type="checkbox"/> Medical Health Provider |
| <input type="checkbox"/> Adult Education or Literacy Program | <input type="checkbox"/> Mental Health Provider |
| <input type="checkbox"/> American Indian VR Services Program | <input type="checkbox"/> Other One-Stop Partner |
| <input type="checkbox"/> Center for Independent Living | <input type="checkbox"/> Other State Agency |
| <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Other State VR Agency |
| <input type="checkbox"/> Community Rehabilitation Program | <input type="checkbox"/> Other WIOA Program (e.g. JobCorps, YouthBuild) |
| <input type="checkbox"/> Community Services Division | <input type="checkbox"/> Public Housing Authority |
| <input type="checkbox"/> Community Services Office | <input type="checkbox"/> Social Security Administration |
| <input type="checkbox"/> Consumer Organization or Advocacy Group | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) - CSD |
| <input type="checkbox"/> Dept. of Labor Employment and Training Program | <input type="checkbox"/> Veteran's Benefits Administration |
| <input type="checkbox"/> Educational Institution (High School) | <input type="checkbox"/> Veteran's Health Administration |
| <input type="checkbox"/> Educational Institution (Post-Secondary / College) | <input type="checkbox"/> WA State Department of Corrections |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Wagner-Peyser Employment Service Program |
| <input type="checkbox"/> Extended Employment Provider | <input type="checkbox"/> Welfare Agency (DSHS) |
| <input type="checkbox"/> Faith Based Organization | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Family / Friend | <input type="checkbox"/> Other Source |
| <input type="checkbox"/> Foster Youth | |
| <input type="checkbox"/> Intellectual / Developmental Disabilities Provider | |

Financial Support Information

15. Do you receive public financial support? If so, what is the approximate monthly amount you receive from each source?

- | | |
|--|------------------|
| <input type="checkbox"/> None | |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI) | Amount: \$ _____ |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | Amount: \$ _____ |
| <input type="checkbox"/> Employment Security (Unemployment Benefits) | Amount: \$ _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) for the Aged, Blind, or Disabled | Amount: \$ _____ |
| <input type="checkbox"/> Veteran's Disability Benefits | Amount: \$ _____ |
| <input type="checkbox"/> Worker's Compensation | Amount: \$ _____ |
| <input type="checkbox"/> General Assistance (state or local) | Amount: \$ _____ |

Total Amount: \$ _____

Medical Information

16. Do you have any medial insurance coverage at the time of this application?

- | | |
|---|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private insurance through other source |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Not yet eligible for private insurance through current employer but will be eligible after a certain period of time. |
| <input type="checkbox"/> Affordable Care Act Exchange | <input type="checkbox"/> Individual does not have medical insurance coverage. |
| <input type="checkbox"/> Private insurance through own employer | |
| <input type="checkbox"/> Public insurance from other sources (Worker's Compensation, Children's Health Insurance Program, etc.) | |

Veteran Status Information

17. What is your veteran's status at the time of this application?

- | | |
|---|---|
| <input type="checkbox"/> I am not a veteran | <input type="checkbox"/> I am a veteran |
| If a veteran, what type of discharge did you receive: <input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> Other | |

Required Disclosures and Consent

18. REQUIRED DISCLOSURES AND CONSENT

I hereby apply to the Division of Vocational Rehabilitation (DVR) for services that will enable me to achieve an employment outcome. I understand that consistent with Title VI of the Civil Rights Act of 1964, as amended and Washington State Laws, against discrimination, the Washington State Department of Social and Health Services prohibits discrimination based on race, color, creed, religion, national origin, age, sex, presence of any sensory, mental or physical disability, use of a trained dog guide or service animal by a person with a disability, sexual orientation, honorably discharged veteran, disabled veteran, Vietnam Era veteran, recently separated veteran, other protected veteran or military status, or status as a mother breastfeeding her child.

I have received the "Your Rights as a DVR Customer" brochure, and/or the URL to the brochure online, and I understand that if I experience discrimination at DVR, I can follow the complaint process outlined in the brochure.

I understand that DVR may obtain personal information from state and federal agencies to verify my benefits, earnings and income from employment or self-employment. The authority under which the information is collected includes WAC 388-891A-0103, 34 CFR 361.38 (Code of Federal Regulations), and RCW 50.13.060 for Employment Security, and RCW 82.32.330 for Department of Revenue.

I have received information about the Client Assistance Program and their services were explained to me. I also understand that, in accordance with WAC 388-891A-0215, if at any time I am dissatisfied with any decision made by DVR, I have the right to contact the Client Assistance Program, request mediation, and request a formal hearing.

I understand that a DVR counselor must determine whether or not I am eligible for Vocational Rehabilitation Services. An assessment may be needed to determine eligibility and I am available to participate in that assessment.

I understand that although DVR is not an entity covered by the Health Information Portability and Accountability Act (HIPAA), DVR will keep my personal information confidential as described in WACs 388-891A-0130, 388-891A-0135, and 388-891A-0150

I authorize DVR to obtain and disclose the required information to DSHS client registry system. This information includes: Name; social security number; birth date; gender; ethnic background; current treatment agency / facility; and DSHS program involvement

My signature indicates that I have read and understand the information on this form.

I am authorized to sign because I am the: **Applicant** **Legal Guardian** **Parent of a Minor**

| | |
|---|--------------------------------------|
| 19. SIGNATURE OF APPLICANT / PARENT / LEGAL GUARDIAN DATE | PRINTED NAME IF NOT APPLICANT |
|---|--------------------------------------|

To be Completed by Division of Vocational Rehabilitation Staff

| | |
|--|--|
| NAME OF DVR STAFF ASSIGNED TO APPLICANT | DATE COMPLETED APPLICATION RECEIVED |
|--|--|