Washington State Department of Social & Health Services
Transforming lives

Application for Vocational Rehabilitation Services

1. SOCIAL SECURITY NUMBER	2. APPLICANT'S FIRST NAME MIDDLE INITIAL LAST NAME	
3. GENDER ☐ Male ☐ Female	4. BIRTHDATE	5. COUNTY
6. STREET ADDRESS	CITY STATE ZIP CODE	
7. TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ Fax ☐ TTY	8. EMAIL ADDRESS	
	9. VIDEOPHONE IP	

10. I currently receive: ☐ SSDI ☐ SSI - Disabled

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 DSHS Nondiscrimination Policy brochure, DSHS 22-171, and understand that if I believe that I have been discriminated against, I can follow the discrimination complaint steps 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 understood the information on this form.

SIGNATURE OF APPLICANT / PARENT / GUARDIAN	APPLICATION DATE

TO BE COMPLETED BY DIVISION OF VOCATIONAL REHABILITATION (DVR) STAFF ONLY

DVR STAFF ASSIGNED TO APPLICANT