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|  | | 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  Male  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)  CELL  TTY/TDD | | | | | | | | | | | | 14. TELEPHONE NUMBER (INCLUDE AREA CODE)  CELL  TTY/TDD | | | | | | | |
| 15. MARITAL STATUS  Never married  Married  Separated  Divorced  Domestic partnership  Widowed | | | | | | | | | | | | | | | | | | | |
| 16. Number of dependents: Number in family: | | | | | | | | | | | | | | | | | | | |
| 17. HOUSEHOLD MEMBER NAMES | | | | | RELATIONSHIP | | | | AGE | | | HOUSEHOLD MEMBER NAMES | | | | | RELATIONSHIP | | AGE |
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| 18. LIVING ARRANGEMENT  Private residence  Adult correctional facility  Community residential / group home  Halfway house  Rehabilitation facility  Substance abuse treatment center  Mental health facility  Homeless / shelter  Nursing home  Other: | | | | | | | | | | | | | | | | | | | |
| 19. 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:  Physical  Alcohol/drugs  Psychiatric/emotional  Neurological  Sensory (hear/see)  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?  Vision  Hearing  Speech  Bowels  Head injury or stroke  Tumor / cancer  High blood pressure  Blackouts / fainting  Heart  Seizures / convulsions  Blood disorder  Insomnia  Asthma / shortness of breath  Headaches  Allergies / rashes  Chronic pain  Stomach, intestines  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?  Stamina / strength  Depression  Remembering things  Anger or short temper  Following instructions  Reading or writing  Stress  Concentration  Getting along with others  Coordination  Working slowly  Math  Absent from work a lot  Speech  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 | | | | | | | | | | | |
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| 12. Have you ever been hospitalized for your condition(s)?  Yes  No | | | | | | | | | | | | | | | | | | | |
| DATES OF TREATMENT | HOSPITAL | | | | | | | ADDRESS | | | | | | | | | | | |
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| 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 | | | |
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| List schools or training: | | | | | | | | | | | List special skills, certificates or licenses: | | | | | | | | |
| 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?  Employed full or part time  Employment with supported employment services  Extended Employment (a sheltered workshop)  Not employed, attending college  Self-Employment  Not employed, attending high school or GED program  State Agency-Managed Business Enterprise Program (BEP)  Not employed, attending trainee, intern or volunteer  Unpaid family worker (family business or farm)  Not employed, other  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:  Hour  Week  Bi-week  Month  Annual | | | | | | | | | | | | | | | | | | NUMBER OF HOURS WORKED PER WEEK | |
| SKILLS/DUTIES | | | | | | | | | | REASON FOR LEAVING | | | | | | | | | |
| JOB TITLE | | | | | | | | | | | | | START DATE | | | | | END DATE | |
| EMPLOYER | | | | | | | | | | | | | CITY AND STATE | | | | | | |
| Salary: $  per:  Hour  Week  Bi-week  Month  Annual | | | | | | | | | | | | | | | | | | NUMBER OF HOURS WORKED PER WEEK | |
| SKILLS/DUTIES | | | | | | | | | | REASON FOR LEAVING | | | | | | | | | |
| JOB TITLE | | | | | | | | | | | | | START DATE | | | | | END DATE | |
| EMPLOYER | | | | | | | | | | | | | CITY AND STATE | | | | | | |
| Salary: $  per:  Hour  Week  Bi-week  Month  Annual | | | | | | | | | | | | | | | | | | NUMBER OF HOURS WORKED PER WEEK | |
| SKILLS/DUTIES | | | | | | | | | | REASON FOR LEAVING | | | | | | | | | |

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| 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 |
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| 1. 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): | | | | | |

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| **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  Affordable Care Act Exchange  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  Mental Health Provider (Public or Private)  American Indian VR Services Program  One-Stop Employment Training Centers (WorkSource)  Centers for Independent Living  Public Housing Authority  Child Protective Services  Social Security Administration (SSA)  Community Rehabilitation Programs  State Department of Corrections/Juvenile Justice  Consumer Organizations or Advocacy Groups  State Employment Security Agency (Employment Security)  Educational Institutions (Elementary/High School)  Veteran’s Administration  Educational Institutions (Post-Secondary/College)  Welfare Agency (State or local government) (DSHS)  Employers  Worker’s Compensation (L&I)  Employment Networks  Other VR State Agencies  Federal Student Aid (such as, Pell Grants, etc.)  Other State Agencies  Intellectual and Developmental Disabilities Agencies  Other Services  Medical Health Provider (Public or Private) | | | |
| 2. Who referred you to DVR? If you were not referred, select Self-Referral.  Self-Referral  FLSA 14(c) Certificate Holder  Juvenile Rehabilitation  Adult Education and/or Literacy Program  Medical Health Provider (Public or Private)  American Indian VR Services Program  Mental Health Provider (Public or Private)  Center for Independent Living  Public Housing Authority (HUD)  Child Protective Services  Social Security Administration  Community Rehabilitation Programs  State Department of Correction  Consumer Organization or Advocacy Group  Temporary Assistance for Needy Families (TANF)  Elementary or Secondary Educational Institution  Wagner-Peyser Employment Service Program  Institution of Higher Education  State or Local Welfare Agency (DSHS)  Employers  Worker’s Compensation (L&I)  Extended Employment Provider  Other One-Stop Partner (e.g. Unemployment, SCSEP)  Faith Based Organization  Other Sources  Family and Friends  Other State Agencies  Intellectual and Developmental Disabilities Providers  Other VR State Agencies (e.g. DSB, L&I)  Department of Labor Employment and Training Services Program for Adults, Dislocated Workers, and Youth  Other WIOA-funded Programs including Job Corps, YouthBuild, Indian and Native Americans, and Migrant and Seasonal Farmworker Programs  Veteran’s Benefits Administration (including the VA Vocational Rehabilitation Program)  Veteran’s Health Administration (including the VA Hospital System, VA Transitional Living, VA Transitional Employment, and compensated work therapy programs) | | | |
| 3. HAVE YOU BEEN INVOLVED   WITH DVR BEFORE?  Yes  No | IF YES, WHEN | WHERE | |
| VOCATIONAL REHABILITATION COUNSELOR’S NAME | | YOUR NAME (IF DIFFERENT THEN) | |
| 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? | | | |