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|  | DIVISION OF VOCATIONAL REHABILITATION (DVR)  **Application for Vocational Rehabilitation Services** | | | | |
| **Applicant Information** | | | | | |
| **1. APPLICANT’S FIRST NAME MIDDLE INITIAL LAST NAME** | | | | | **2. GENDER**  Male  Female  X  Non-Binary  Other:  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 ZIP CODE** | | | | | |
| **10. PREFERRED COMMUNICATION**  Email  Telephone  Mail  Other: | | | **11. LANGUAGE ACCESS ACCOMMODATION?**  Yes  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:**   Yes  No  **Student with a disability:**  0. Individual is not a student with a disability  1. Student with a disability and receiving 504 accommodation  2. Student with a disability and receiving transition services under an IEP  3. Student with a disability, no 504 accommodation, and not receiving transition services under an IEP.  **Individual with a disability:**  1. Individual reports that he / she has any disability, as defined in the Americans with Disabilities Act  0. Individual reports that he / she does not have a disability that meets the definition  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:  Not Hispanic / Latino  Mexican American  Puerto Rican  Hispanic / Latino  Cuban  Chicano  Did not self-identify  Other (please specify):  **Race:**  Please check the appropriate box(es) below regarding your race / ethnicity.  American Indian / Alaska Native; if checked, please list Tribe / Community Attachment:  Black / African American  Cambodian  Chinese  Filipino  Guamanian  Hawaiian  Indian (Southeast Asian)  Korean  Laotian  Samoan   Thai  Vietnamese  Japanese  White / European American  Other Asian or Pacific Islander (please specify):  Other (please specify):  Do not wish to disclose  Not reported | | | | | |
| **Referral Information** | | | | | |
| **14. Who referred you to DVR? If you were not referred, please select “Self Referral.”**  Self Referral  14(c) Certificate Holder  Juvenile Rehabilitation Youth  Adult Education or Literacy Program  Medical Health Provider  American Indian VR Services Program  Mental Health Provider  Center for Independent Living  Other One-Stop Partner  Child Protective Services  Other State Agency  Community Rehabilitation Program  Other State VR Agency  Community Services Division  Other WIOA Program (e.g. JobCorps, YouthBuild)  Community Services Office  Public Housing Authority  Consumer Organization or Advocacy Group  Social Security Administration  Dept. of Labor Employment and Training Program  Temporary Assistance for Needy Families (TANF) - CSD  Educational Institution (High School)  Veteran’s Benefits Administration  Educational Institution (Post-Secondary / College)  Veteran’s Health Administration  Employer  WA State Department of Corrections  Extended Employment Provider  Wagner-Peyser Employment Service Program  Faith Based Organization  Welfare Agency (DSHS)  Family / Friend  Workers Compensation  Foster Youth  Other Source  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?**  None  Social Security Disability Insurance (SSDI) Amount: $  Temporary Assistance for Needy Families (TANF) Amount: $  Employment Security (Unemployment Benefits) Amount: $  Supplemental Security Income (SSI) for the Aged, Blind, or Disabled Amount: $  Veteran’s Disability Benefits Amount: $  Worker’s Compensation Amount: $  General Assistance (state or local) Amount: $  Total Amount: $ | | | | | |
| **Medical Information** | | | | | |
| **16. Do you have any medial insurance coverage at the time of this application?**  Medicaid  Private insurance through other source  Medicare  Not yet eligible for private insurance through current employer  Affordable Care Act Exchange but will be eligible after a certain period of time.  Private insurance through own employer  Individual does not have medical insurance coverage.  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?**  I am not a veteran  I am a veteran  If a veteran, what type of discharge did you receive:  Honorable  Dishonorable  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** | |