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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 ISSUESDo 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 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| 12. Have you ever been hospitalized for your condition(s)? [ ]  Yes [ ]  No |
| DATES OF TREATMENT | HOSPITAL | ADDRESS |
|  |  |  |
| REASON |
|  |  |  |
| 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: |
| 4. MILITARY SERVICEHave 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 |
|  |  |  |  |
|  |  |  |  |
| 1. PARENT OR LEGAL GUARDIAN

Are you a minor (under the age of 18) or do you have a court appointed legal guardian? [ ]  Yes [ ]  NoIf 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? |