DWS-USOR 4
Rev. 07/2017

State of Utah
Department of Workforce Services
VOCATIONAL REHABILITATION APPLICATION

A proud partner of the americanjobcenter network

APPLICANT INFORMATION							
Social Security number:			Email:				
Last name:			First name:		Middle initial:		
Gender:	☐ Male	☐ Female	☐ Chooses not to disclose		Birth date:	__/___/____	
Home address:							
City:		State:		ZIP code:			
Mailing Address:							
City:		State:		ZIP code:			
Primary phone:			Secondary phone:				

RACE (SELECT ALL THAT APPLY)	
☐ Black/African American	☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian	☐ Asian
☐ American Indian/Native Alaskan	☐ Chooses not to Identify

ETHNICITY	
☐ Hispanic/Latino	☐ Not Hispanic/Latino

LANGUAGE	
☐ ASL	☐ English
☐ Spanish	☐ Other (specify)

COMMUNICATION PREFERENCE	
☐ ASL	☐ Minimal language skills
☐ Audio tape	☐ Oral
☐ Braille	☐ Tactile
☐ Large print	☐ Total communication

Specific communication needs:

VETERAN STATUS			
Veteran:	☐ Yes	☐ No	Type of discharge:

LIVING ARRANGEMENT	
☐ Private residence (by yourself, with family or others)	☐ Substance abuse treatment center
☐ Adult/youth correctional facility	☐ Mental health facility
☐ Community residential/group home	☐ Nursing home
☐ Homeless shelter	☐ Rehabilitation facility
☐ Halfway house	☐ Other (specify)

MARITAL STATUS				
☐ Married	☐ Never married	☐ Divorced	☐ Separated	☐ Widow

U.S. CITIZENSHIP **IF NOT A US CITIZEN PLEASE BRING USCIS CARD WITH YOU TO YOUR APPOINTMENT**	
☐ Yes, I am a U.S. citizen	☐ Not a U.S. citizen but I have a USCIS Employment Authorization Card
☐ Not a U.S. citizen but I have a USCIS Permanent Resident Card	☐ Not a U.S. citizen, other

BRING PHOTO ID	ID #	

REFERRAL SOURCE
Who referred you to VR?
What is the reason they suggested you should apply?

FINANCIAL
What is your main source of financial support at this time?

IF YOU RECEIVE ANY OF THE FOLLOWING BENEFITS, PLEASE ESTIMATE THE AMOUNT BELOW		
☐ SSI aged $	☐ SSI blind $	☐ SSI disabled $
☐ SSDI disabled $	☐ Veteran's disability benefits $	☐ General Assistance $
☐ Other (specify)		

MEDICAL INSURANCE			
☐ Medicaid	☐ Medicare	☐ Other public (PCN, WC etc.)	☐ No insurance
☐ Private through employer	☐ Other private insurance	☐ Not eligible through employer	

EMPLOYMENT HISTORY		
** IF YOU HAVE A RESUME, PLEASE BRING A COPY TO YOUR APPOINTMENT. IN ADDITION, PLEASE COMPLETE THE EMPLOYMENT HISTORY BELOW**		
Are you currently employed?	☐ Yes	☐ No

LIST WORK HISTORY, IN ORDER, BEGINNING WITH YOUR MOST RECENT JOB					
Job title:		Start date:		Hours worked per week:	
Salary:		Employer:		Date ended:	
Employer address:					
City:		State:		ZIP:	
Job duties:					
Reason job ended:					
Job title:		Start date:		Hours worked per week:	
Salary:		Employer:		Date ended:	
Employer address:					
City:		State:		ZIP:	
Job duties:					
Reason job ended:					
Job title:		Start date:		Hours worked per week:	
Salary:		Employer:		Date ended:	
Employer address:					
City:		State:		ZIP:	
Job duties:					
Reason job ended:					

CONTACTS			
Emergency contact:		Phone number:	
Non-family contact:		Phone number:	

Legal guardian:		Phone number:	
Other contact:		Phone number:	
Probation or parole officer:		Phone number:	

****IF YOU HAVE A LEGAL HISTORY, PLEASE BRING INFORMATION (CHARGES/DATES) TO YOUR APPOINTMENT TO DISCUSS WITH YOUR COUNSELOR****

EDUCATION

What is your highest level of education?		When did you last attend school?	
Are you currently enrolled in school?		If yes, what is the name of the school?	
If in school, who is your primary school contact?		Do you hold any current certifications?	

ARE YOU A STUDENT WITH DISABILITY IN SECONDARY EDUCATION

☐ High school student with an IEP	☐ High school student with a 504 plan	☐ High school student with IEP & 504 plan

IF YOU ARE CURRENTLY TAKING MEDICATIONS, LIST THEM BELOW

1.	Reason prescribed:	
2.	Reason prescribed:	
3.	Reason prescribed:	
4.	Reason prescribed:	
Are you currently taking your prescribed medications?	If not, why?	

****LIST ANY ADDITIONAL MEDICATIONS AND THE REASON YOU ARE PRESCRIBED THEM ON A SEPARATE SHEET OF PAPER FOR YOUR COUNSELOR****

MEDICAL RECORD INFORMATION

Name of treatment provider (doctor, psychologist, other) who know about your disability		Date of treatment:	
Phone number:		Fax number:	
Address:			
Reason for treatment:			

Name of treatment provider (doctor, psychologist, other) who know about your disability		Date of treatment:	
Phone number:		Fax number:	
Address:			
Reason for treatment:			
Name of treatment provider (doctor, psychologist, other) who know about your disability		Date of treatment:	
Phone number:		Fax number:	
Address:			
Reason for treatment:			
DISABILITY INFORMATION			
What is your current disability(ies)?			
How does the disability(ies) affect your ability to work?			
COUNSELOR NOTES:			

Sign the application after reading the following information.

GATHERING INFORMATION TO DETERMINE ELIGIBILITY: The information contained in this application is true and correct to the best of my knowledge. Permission is granted to the Utah State Office of Rehabilitation to make whatever inquiries might be necessary to verify these statements including the sharing of information with the Department of Workforce Services. In applying for Vocational Rehabilitation Services, I understand there is a need to collect personal information. The authority to collect this information comes from Federal Regulation 34 CFR 361.38(a) (1) (iii). I understand that collecting this information is necessary to determine eligibility and therefore is mandatory. Failure to provide requested information may result in a determination of not being eligible for Vocational Rehabilitation Services. I understand that my counselor has 60 days from the date I submit a complete application to determine eligibility, but that circumstances may arise where this information cannot be acquired within this time frame. I agree to sign a request to extend the time for determination of eligibility if I want to have the 60 days extended.

SOCIAL MEDIA: I understand that, in connection with furnishing me with Vocational Rehabilitation services, my counselor may access or view my social media profiles and posts.

CONFIDENTIALITY: I understand that information concerning me is confidential and protected under State & Federal regulations as well as professional codes of ethics governing confidentiality. I recognize this information cannot be disclosed without my written consent, unless otherwise provided for in the State and Federal regulations. However, I understand that information about me may be released to appropriate agencies or individuals without my informed consent in order to accomplish my vocational rehabilitation plan and job placement goals and I understand these agencies and/or individuals will be made known to me. I authorize the exchange of information between the Utah State Office of Rehabilitation and other entities, including the Department of Workforce Services, only for the use of the Utah State Office of Rehabilitation as needed to determine eligibility and appropriate services and for the administration of their program. I further understand that, at the time my Vocational Rehabilitation case is closed, my contact information may be referred to an Employment Network that has partnered with the Utah State Office of Rehabilitation under a Partnership Plus arrangement for the purpose of providing and coordinating further services I may be eligible to receive.

IN CASE OF A PROBLEM: I understand that a Client Assistance Program (CAP) representative is available to act as my advisor and advocate at any time, and that I may call toll free (1-800-662-9080) to reach the Client Assistance Program (CAP) located at 205 North 400 West, Salt Lake City, Utah 84103.

I understand that I have the opportunity for a timely review of any determination by my rehabilitation counselor. If I am dissatisfied with the furnishing or denial of Vocational Rehabilitation services, I may request a written or verbal review of a determination, or mediation regarding a determination, to my counselor, the immediate supervisor, the District Director, or to: **Division of Rehabilitation Services, Administration Office, 1595 W 500 S, Salt Lake City, Utah 84104.** If I request mediation, my mediator will be chosen randomly from a list of qualified mediators unless the Utah State Office of Rehabilitation and I agree to use a particular mediator. If I request a hearing, the hearing officer will be chosen randomly from a list of qualified Administrative Law Judges unless the Utah State Office of Rehabilitation and I agree to use a particular hearing officer.

NO DISCRIMINATION: I understand that services in this program are provided without regard to sex, race, age, religion, color, or national origin according to Title VI of the Civil Rights Act and

Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act. The agency also assures that no group of individuals will be excluded or found ineligible solely on the basis of type of disability.

I understand that altering this application in any way will make it invalid and I have completed this application in its original form. I understand that I must provide proof of identity and must be able to be legally employed in the United States. I have read (or have had read to me) and understand and agree to the above.

_____ _____

Signature of Applicant/Representative **Date**

_____ _____

Parent Signature (if applicant is a minor) **Date**

_____ _____

Counselor Signature (reviewed and accepted) **Date**