

## 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 <input type="checkbox"/> Male <input type="checkbox"/> 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) <input type="checkbox"/> CELL <input type="checkbox"/> TTY/TDD	14. TELEPHONE NUMBER (INCLUDE AREA CODE) <input type="checkbox"/> CELL <input type="checkbox"/> 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

18. LIVING ARRANGEMENT

<input type="checkbox"/> Private residence	<input type="checkbox"/> Adult correctional facility
<input type="checkbox"/> Community residential / group home	<input type="checkbox"/> Halfway house
<input type="checkbox"/> Rehabilitation facility	<input type="checkbox"/> Substance abuse treatment center
<input type="checkbox"/> Mental health facility	<input type="checkbox"/> Homeless / shelter
<input type="checkbox"/> Nursing home	<input type="checkbox"/> 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:

<input type="checkbox"/> Physical	<input type="checkbox"/> Alcohol/drugs	<input type="checkbox"/> Psychiatric/emotional
<input type="checkbox"/> Neurological	<input type="checkbox"/> Sensory (hear/see)	<input type="checkbox"/> 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?

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Vision                       | <input type="checkbox"/> Hearing                | <input type="checkbox"/> Speech              | <input type="checkbox"/> Bowels               |
| <input type="checkbox"/> Head injury or stroke        | <input type="checkbox"/> Tumor / cancer         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blackouts / fainting |
| <input type="checkbox"/> Heart                        | <input type="checkbox"/> Seizures / convulsions | <input type="checkbox"/> Blood disorder      | <input type="checkbox"/> Insomnia             |
| <input type="checkbox"/> Asthma / shortness of breath | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Allergies / rashes  | <input type="checkbox"/> Chronic pain         |
| <input type="checkbox"/> Stomach, intestines          | <input type="checkbox"/> 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?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Stamina / strength        | <input type="checkbox"/> Depression         | <input type="checkbox"/> Remembering things | <input type="checkbox"/> Anger or short temper |
| <input type="checkbox"/> Following instructions    | <input type="checkbox"/> Reading or writing | <input type="checkbox"/> Stress             | <input type="checkbox"/> Concentration         |
| <input type="checkbox"/> Getting along with others | <input type="checkbox"/> Coordination       | <input type="checkbox"/> Working slowly     | <input type="checkbox"/> Math                  |
| <input type="checkbox"/> Absent from work a lot    | <input type="checkbox"/> Speech             | <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DATES OF TREATMENT	HOSPITAL		ADDRESS	
REASON				
REASON				
<b>III. Education and Work Study</b>				
1. Are you in high school or in a transition program? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, please answer the following: Do you have a 504 accommodation plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you receiving services under an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. Did you complete high school? <input type="checkbox"/> Yes <input type="checkbox"/> No      Did you get a diploma or GED? <input type="checkbox"/> Yes <input type="checkbox"/> No				
SCHOOL NAME		YEAR COMPLETED	CITY AND STATE	IF NO, WHAT GRADE DID YOU LAST ATTEND?
3. Have you gone to college? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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?

- |   |   |
|---|---|
| <input type="checkbox"/> Employed full or part time   | <input type="checkbox"/> Employment with supported employment services        |
| <input type="checkbox"/> Extended Employment (a sheltered workshop)                                   | <input type="checkbox"/> Not employed, attending college                      |
| <input type="checkbox"/> Self-Employment  | <input type="checkbox"/> Not employed, attending high school or GED program   |
| <input type="checkbox"/> State Agency-Managed Business Enterprise Program (BEP)                       | <input type="checkbox"/> Not employed, attending trainee, intern or volunteer |
| <input type="checkbox"/> Unpaid family worker (family business or farm)                               | <input type="checkbox"/> Not employed, other                                  |
| <input type="checkbox"/> 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: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-week <input type="checkbox"/> Month <input type="checkbox"/> Annual			NUMBER OF HOURS WORKED PER WEEK
SKILLS/DUTIES		REASON FOR LEAVING	
JOB TITLE		START DATE	END DATE
EMPLOYER		CITY AND STATE	
Salary: \$ _____ per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-week <input type="checkbox"/> Month <input type="checkbox"/> Annual			NUMBER OF HOURS WORKED PER WEEK
SKILLS/DUTIES		REASON FOR LEAVING	
JOB TITLE		START DATE	END DATE
EMPLOYER		CITY AND STATE	
Salary: \$ _____ per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-week <input type="checkbox"/> Month <input type="checkbox"/> Annual			NUMBER OF HOURS WORKED PER WEEK
SKILLS/DUTIES		REASON FOR LEAVING	

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

**2. 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): \_\_\_\_\_

**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
- American Indian VR Services Program
- Centers for Independent Living
- Child Protective Services
- Community Rehabilitation Programs
- Consumer Organizations or Advocacy Groups
- Educational Institutions (Elementary/High School)
- Educational Institutions (Post-Secondary/College)
- Employers
- Employment Networks
- Federal Student Aid (such as, Pell Grants, etc.)
- Intellectual and Developmental Disabilities Agencies
- Medical Health Provider (Public or Private)
- Mental Health Provider (Public or Private)
- One-Stop Employment Training Centers (WorkSource)
- Public Housing Authority
- Social Security Administration (SSA)
- State Department of Corrections/Juvenile Justice
- State Employment Security Agency (Employment Security)
- Veteran's Administration
- Welfare Agency (State or local government) (DSHS)
- Worker's Compensation (L&I)
- Other VR State Agencies
- Other State Agencies
- Other Services

2. Who referred you to DVR? If you were not referred, select Self-Referral.

- Self-Referral
- FLSA 14(c) Certificate Holder
- Adult Education and/or Literacy Program
- American Indian VR Services Program
- Center for Independent Living
- Child Protective Services
- Community Rehabilitation Programs
- Consumer Organization or Advocacy Group
- Elementary or Secondary Educational Institution
- Institution of Higher Education
- Employers
- Extended Employment Provider
- Faith Based Organization
- Family and Friends
- Intellectual and Developmental Disabilities Providers
- 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)
- Juvenile Rehabilitation
- Medical Health Provider (Public or Private)
- Mental Health Provider (Public or Private)
- Public Housing Authority (HUD)
- Social Security Administration
- State Department of Correction
- Temporary Assistance for Needy Families (TANF)
- Wagner-Peyser Employment Service Program
- State or Local Welfare Agency (DSHS)
- Worker's Compensation (L&I)
- Other One-Stop Partner (e.g. Unemployment, SCSEP)
- Other Sources
- Other State Agencies
- Other VR State Agencies (e.g. DSB, L&I)

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?