Washington State Department of Social & Health Services
Transforming lives

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:
☐ Not Hispanic / Latino
☐ Hispanic / Latino
☐ Did not self-identify

If Hispanic / Latino, please check the appropriate box(es) below:
☐ Mexican American ☐ Puerto Rican
☐ Cuban ☐ Chicano
☐ Other (please specify):

Race:
Please check the appropriate box(es) below regarding your face / ethnicity.

☐ American Indian / Alaska Native; if checked, please list Tribe:
☐ Black / African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian
☐ Hawaiian ☐ Indian (Southeast Asian) ☐ Korean ☐ Laotian ☐ Samoan
☐ Thai ☐ Vietnamese ☐ 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."

- ☐ 14(c) Certificate Holder
- ☐ Adult Education or Literacy Program
- ☐ American Indican VR Services Program
- ☐ Center for Independent Living
- ☐ Child Protective Services
- ☐ Community Rehabilitation Program
- ☐ Community Services Division
- ☐ Community Services Office
- ☐ Consumer Organization / Advocacy
- ☐ Self Referral
- ☐ Department of Labor Employment and Training Program
- ☐ Educational Institution (High School)
- ☐ Educational Institution (Post-Secondary / College)
- ☐ Employer
- ☐ Extended Employment Provider
- ☐ Faith Based Organization
- ☐ Family / Friend
- ☐ Foster Youth
- ☐ 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?

- ☐ Social Security Disability Insurance (SSDI)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Employment Security (Unemployment Benefits)
- ☐ Supplemental Security Income (SSI) for the Aged, Blind, or Disabled
- ☐ Veteran's Disability Benefits
- ☐ Worker's Compensation
- ☐ General Assistance (state or local)
- ☐ None

Validated SSDI Amount: $_____

Validated SSI Amount: $_____

All other public support: $_____

Total Amount: $_____

Medical Information

16. Do you have any medial insurance coverage at the time of this application?

- ☐ Medicaid
- ☐ Medicare
- ☐ Affordable Care Act Exchange
- ☐ Private insurance through own employer
- ☐ Public insurance from other sources (Worker's Compensation, Children's Health Insurance Program, etc.)
- ☐ Private insurance through other source
- ☐ Not yet eligible for private insurance through current employer but will be eligible after a certain period of time.
- ☐ Individual does not have medical insurance coverage.

Veteran Status Information

17. What is your veteran's status at the time of this application?

- ☐ Individual is not a veteran
- ☐ Individual is a veteran

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 DSHS Nondiscrimination Policy brochure, DSHS 22-171, and understand that if I believe that I have been discriminated against, I can follow the discrimination complaint steps 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

SIGNATURE OF DVR STAFF ASSIGNED TO APPICANT DATE	**PRINTED NAME**