‘Nevada Department of Employment, Training and Rehabilitation

Application for Vocational Rehabilitation Service

Case# ________	SOCIAL SECURITY # ___ ___ ___ ---- ___ ___ ---- ___ ___ ___ ___			
LAST NAME		FIRST NAME		MIDDLE INITIAL
PREVIOUS NAMES USED		GENDER ☐MALE ☐FEMALE		
CURRENT STREET ADDRESS			Apt #	
CITY	STATE		ZIP CODE	
MAILING ADDRESS (If Different From Current Address)				
CITY	STATE		ZIP CODE	
COUNTY	TELEPHONE# ( )		CELL# ( )	
DATE OF BIRTH	EMAIL ADDRESS			
DIRECTIONS (MAJOR CROSS STREET)				
U.S. MILITARY VETERAN? ☐YES ☐NO		U.S. CITIZEN? ☐YES ☐NO		
If No: Do you have an Alien Registration Card? ☐YES ☐NO		EMPLOYMENT AUTHORIZATION DOCUMENT? ☐YES ☐NO		

RACE/ETHNICITY: (CHECK ONE OR MORE)	LANGUAGE ABILITIES:
☐WHITE ☐BLACK OR AFRICAN AMERICAN ☐ASIAN ☐AMERICAN INDIAN / ALASKA NATIVE ☐NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐HISPANIC/LATINO	(CHECK ONE FOR EACH BELOW) ENGLISH READING: ☐FUNCTIONAL ☐ LIMITED ☐UNKNOWN ENGLISH SPEAKING: ☐FUNCTIONAL ☐LIMITED ☐UNKNOWN PRIMARY LANGUAGE:_______________________

TRANSITION/TRAINING(TRANSITION STUDENTS ONLY)

Current Grade Level:__________

School Name:____

County:____

Out of State School Name:____

(If You are attending a School outside of the State of Nevada)

CONTACT PERSON'S NAME AND TELEPHONE NUMBER
SOMEONE WHOSE PHONE NUMBER IS DIFFERENT THAN YOURS WHO WOULD BE ABLE TO GIVE YOU A MESSAGE

Name:____

Relationship:____

Phone number: (_____)____

Name:____

Relationship:____

Phone number: (_____)____

Contact Person NOT Living in your home

Name:____

Relationship:____

Phone number: (_____)____

RECEIVED BY:	DATE RECEIVED(FOR OFFICE USE ONLY)
Agency Representative:___________________________	

WHO REFERRED YOU? CHECK / CIRCLE ONE:

☐Social Security Administration or Disability Determination Services

☐Doctor, Hospital, Mental Health

☐Law enforcement, Corrections, Court

☐Job Connect, Workers' Comp.

☐Rehabilitation program in your community

☐University, College, or Vocational school

☐Self-referral, Friend, Family

☐Welfare or public assistance agency

☐Grade school or high school ☐Veteran's Administration

☐Other: ________________________________

PLEASE CHECK ONE OF THE FOLLOWING WHICH BEST DESCRIBES YOUR CURRENT LIVING ARRANGEMENT:

☐Private residence (On your own, with family or roommate) ☐Group home

☐Rehabilitation facility ☐Other

☐Mental health facility ☐Nursing home ☐Jail/Adult correctional facility

☐ Substance abuse treatment center ☐Halfway house ☐Homeless/shelter

WOULD YOU LIKE TO REGISTER TO VOTE TODAY: ☐Yes ☐No Form#____________________

PLEASE SELECT ONE: ☐Currently registered ☐Not Eligible ☐Not Interested

COUNTY SERVED IN (CIRCLE ONE):

Carson City, Churchill, Clark, Douglas , Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, Washoe, White Pine

MARITAL STATUS (Check one):

☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

FINANCIAL:

WHAT IS YOUR GROSS MONTHLY FAMILY INCOME? _____________________

Household Information:

Number in Family __________ **Number of Dependents** ___________

Parents monthly income if under age 18 ______________________________

House hold members:

Name: ____ **Age:**____________________

Relationship: ________________________________ **Occupation:**____________________

Name: ____ **Age:**____________________

Relationship: ________________________________ **Occupation:**____________________

Name: ____ **Age:**____________________

Relationship: ________________________________ **Occupation:**____________________

Name: ____ **Age:**____________________

Relationship: ________________________________ **Occupation:**____________________

What is your primary source of income? Please check one:

☐Your personal income (earnings, interest, dividends, rent)

☐Your spouse's income, or support from family and friends

☐Public Institution- Tax Supported

☐Public assistance such as SSDI, SSI, TANF, etc.

☐Annuity or Non-Disability Benefit

☐Private Relief Agency

☐Worker's Compensation

Do you have any of the following types of medical insurance coverage? Check one or more:

☐Medicaid ☐Medicare ☐No Medical Insurance Coverage

☐Private insurance through other means (for example, insurance through your parents or spouse)

☐Private insurance through employment

☐Insurance Company

☐Workers' Compensation

☐Other Public Insurance____________________________________

Are you receiving Disability Benefits? Please Check One:

SSDI(Social Security Disability Insurance):

☐Allowed Benefits, ☐Denied Benefits, ☐Benefits Terminated/Discontinued, ☐Application Pending,

☐Not An Applicant, ☐Unknown

SSI Status(Supplemental Security Income):

☐Allowed Benefits, ☐Denied Benefits, ☐Benefits Terminated/Discontinued,

☐Application Pending,☐ Unknown

Are you currently receiving any of the following? If yes, please list the MONTHLY amount.

☐SSDI (Social Security Disability Insurance) Amount: $___________

☐SSI (Supplemental Security Income) Amount: $___________

☐TANF (Temporary Assistance for Needy Families) Amount: $___________

☐General Assistance (Public Assistance) Amount: $___________

☐Veterans' disability benefits Amount: $___________

☐Workers Compensation Amount: $___________

☐ Any other public support Amount: $___________

(Please Specify i.e. Unemployment or other benefits)____

IDENTIFICATION

Provide verification for the following identification:

One (1) Item from List A **OR** One (1) Item from List B **AND** One (1) Item from List C

List A

- United States Passport
- Certificate of United States Citizenship
- Certificate of Naturalization
- Unexpired Foreign Passport w/Attached Employment Authorization
- Alien Registration Card w/Photograph

List B

- State issued Driver's License or State I.D. Card w/Picture or Information (Name, Sex, Date of Birth, Height, Weight & Color of Eyes)
- U.S. Military I.D. Card

AND

List C

- Original Social Security Card to be Witnessed at Intake
- Birth Certificate Issued by State, County or Municipal Authority
- Unexpired INS Employment Authorization

What is your highest level of education? Check one:

☐ High school diploma or GED (high school equivalency certificate)

☐No formal schooling

☐Some elementary school (grades 1-8)

☐Some high school (grades 9-12) but no high school diploma

☐Special education certificate of completion/attendance

☐Still in High School Name:________________

Present Current Grade___________________

☐Some college/voc-tech – No degree

☐Vocational/Technical Certificate

☐Associates Degree School Name:______________________ Degree:______________________

☐Bachelor's Degree School Name:______________________ Degree:______________________

☐Master's Degree or Higher

School Name:______________________ Degree:______________________

WHILE IN SCHOOL, DID YOU EVER HAVE AN INDIVIDUALIZED EDUCATION PROGRAM (IEP SPECIAL EDUCATION) OR A SECTION 504 ACCOMMODATION PLAN?

Individualized Educations Plan ☐YES ☐NO

Section 504 Accommodation Plan ☐YES ☐NO

How can the Bureau be of assistance to you? What employment related services are you seeking:

Employment:

Year Last Worked_______________

Work Status at Application (Check one of the following)

☐Trainee/Intern/Volunteer ☐Homemaker

☐Unemployed ☐Competitive Employment ☐Self Employed

If you are employed, how many hours do you usually work per week? _____________

If you are employed, what are your current WEEKLY earnings? $_________________

(gross wages, salaries, tips or commissions before payroll or tax deductions)

COMMUNICATION ACCOMMODATIONS	**Have you ever been convicted of a felony?**
☐ Regular print ☐ Braille ☐ Other language (specify) ☐ Large print	☐ Yes ☐ No Details:_________________________________
What is your primary means of transportation? ☐ Personal Vehicle ☐ Public Transportation ☐ Other_______________________	Probation Officer: _________________________ Phone # ________________________________

<u>WORK HISTORY</u> ☐ **Check here if no work history** If currently working how many hours per week do you work? ____________Hourly Wage: ____________

List current or last Job first. If you run out of space you may continue on the back side of this sheet.

Name of Employer:	
Address:	
Job Duties:	
Title of Position Held:	**Dates of Employment:** **From**: ______________ **To**:_____________ MONTH/YEAR MONTH/YEAR
Reason for leaving:	
Name of Employer:	
Address:	
Job Duties:	

Title of Position Held:	**Dates of Employment:** **From**: ______________ **To**:______________ MONTH/YEAR MONTH/YEAR
Reason for leaving:	
Name of Employer:	
Address:	
Job Duties:	
Title of Position Held:	**Dates of Employment:** **From**: ______________ **To**:______________ MONTH/YEAR MONTH/YEAR
Reason for leaving:	
Name of Employer:	
Address:	
Job Duties:	
Title of Position Held:	**Dates of Employment:** **From**: ______________ **To**:______________ MONTH/YEAR MONTH/YEAR
Reason for leaving:	

DISABILITY (Check all that apply)

What is the primary medical condition, injury, physical/mental impairment or disability that limits your ability to work?

____

____

When did these impairments/disabilities begin? ____________
Month / Year

☐AIDS/HIV
☐ Amputation
☐ Attention Deficit Disorder
☐ Back Injury
☐ Brain Injury
☐ Carpal Tunnel
☐ Cognitive Disability
☐Deaf - Blind
☐ Depression
☐ Epilepsy
☐ Heart Disease
☐ Hip/Knee, Other Joint Dysfunction
☐ Mental Illness
☐ Multiple Sclerosis
☐Post Paraplegia or Quadriplegic
☐Respiratory/Pulmonary/Allergies
☐Specific Learning Disability
☐Alcohol or Other Drug Disorder
☐ Arthritis
☐ Autism
☐ Blindness or Visual Impairment
☐ Cancer
☐ Cerebral Palsy (CP)
☐ Cystic Fibrosis
☐ Deaf or Hard of Hearing
☐ Diabetes
☐ Fibromyalgia
☐ Hemophilia
☐ Kidney Failure
☐ Muscular Dystrophy
☐ Myofascial Disorder
☐Post Traumatic Stress Disorder
☐Severe Arthritis
☐ Spinal Cord Injury
☐Stroke
☐Other____
☐Unknown____

CURRENT PHYSICIAN / MEDICAL PROFESSIONAL

1. Name ____
Type of Physician____
Address ____
Phone____
Fax Number____

2. Name ____
Type of Physician____
Address ____
Phone____
Fax Number ____

3. Name ____
Type of Physician_____________________________________
Address ____
Phone:____
Fax Number ____

If additional space is needed please enter information on the back of this page.

HOSPITALIZATIONS

Name of Hospital:____
Address:____
Reason:____

Name of Hospital:____
Address:____
Reason:____

LIST OF MEDICATIONS

____
____
____
____
____
____
____

CONFIDENTIAL PERSONAL INFORMATION

The Bureau of Vocational Rehabilitation is a state and federally funded agency that assists persons with disabilities in achieving or maintaining employment. I understand that it is necessary for the Bureau to collect personal information in connection with my rehabilitation program.

- I understand that my eligibility and/or provision of services may be impacted if I refuse to provide personal information that is requested by the Bureau.
- I understand that my personal information will be held confidential by the Bureau and will not be disclosed to any other person or entity except as noted in the Information and Disclosure Form.

Section 504(A) of the Workforce Investment Act of 1998; Section 12c of the Rehabilitation Act of 1973 as Amended; 29USC711c and 721(a)(6)(A); 34CFR361.38; NRS 426.573, 426.610, 432B.220, 615.280, 615.290; 629.061

INACCURATE OR MISLEADING INFORMATION

If you believe that information in your record of services is inaccurate or misleading, you may request that the Bureau of Vocational Rehabilitation amend the information. If the information is not amended, the request for an amendment must be documented in the record of services.

LIABILITY OF STATE FOR THIRD PARTY ACTIONS

The state of Nevada, Nevada Department of Employment, Training & Rehabilitation, the Rehabilitation Division and the Bureau of Vocational Rehabilitation and their officers, agents, employees and elected and appointed officials are not responsible in any manner for damages caused to a client by third-parties, including, but not limited to vendors on an approved list maintained by the State of Nevada, Nevada Department of Employment, Training & Rehabilitation, the Rehabilitation Division and the Bureau of Vocational Rehabilitation and hereby specifically disclaim any liability therefore. In addition, the State of Nevada will not waive and intends to assert available NRS chapter 41 liability in all cases.

PRIOR AUTHORIZATION STATEMENT

I understand the Bureau of Vocational Rehabilitation will not pay for any service which my counselor HAS NOT AUTHORIZED IN WRITING. If my counselor approves a medical examination, this is NOT approval for treatment or surgery. When a doctor, hospital, merchant or other vendor has not received advance approval from my counselor, I understand I may have to pay for any goods or services myself.

CLIENT FINANCIAL PARTICIPATION

I understand that I will be asked to furnish financial information and my financial needs will be considered in determining my participation in the cost of those vocational rehabilitation services which require the expenditure of case service dollars. I will not be required to participate in the cost of diagnostic services to evaluate my rehabilitation potential, counseling guidance and referral services, or placement services.

In making this application for vocational rehabilitation services, I acknowledge that:

- I am applying for vocational rehabilitation services for the specific purpose of getting and/or keeping a job
- It is my responsibility to inform my counselor of any changes related to this application, such as changes in my address, income or employment.
- Prior written approval from my counselor is needed before Rehabilitation Services will pay for any services.
- Payment for some services may be based on financial need according to my personal or family income.
- I expressly give my permission for information about me to be shared within the Department (DETR). Rehabilitation Services will also have access to information in my Social Security, Disability Determination, SRS, and employment records.
- No one will be discriminated against by Rehabilitation Services because of disability, race, religion, sex, color, national origin, length of residency in the state, or ancestry.

ACKNOWLEDGEMENT OF ACCEPTANCE

Please write your initials beside each document you have received.

_____ I have been provided the agency's Information and Disclosure Sheet and informed about the protection, use and release of personal information and the conditions under which my personal information may be released without my written consent.

_____ I have been informed regarding the risks of electronic communication. I agree to the exchange of information regarding myself through the following methods (initial all that apply):

Telephone: _____Detailed message _____Message to return call only
_____No message
Email: _____Email communication _____Do not email
Fax: _____ Fax _____Do not fax
Mail: _____Only hand deliver or mail information regarding me ____ Do not mail

*Other:*____

_____ I have been informed of my opportunity for review of decisions made by my Rehabilitation Counselor regarding my application, eligibility and the furnishing or denial of service if I do not agree with the decision.

_____ I have been informed of the Client Assistance Program and have been provided a copy of the steps I need to take concerning communication and formal appeal.

_____ I have been informed of and have been provided a copy of the Participant Bill of Rights.

_____ I have been informed of the professional qualifications of VR Counselors. I agree to enter into a rehabilitation counseling relationship at this time.

Applicant signature_________________________________Date____________________

Parent/Guardian/Legal Rep Signature____

Date______________________

Signature of Individual who filled out application if different from above

____

Parent/Guardian/or Representative's Address

____

Telephone Number____

Email address____