Washington State Department of Social & Health Services
Transforming lives

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

18. LIVING ARRANGEMENT

☐ Private residence
☐ Community residential / group home
☐ Rehabilitation facility
☐ Mental health facility
☐ Nursing home
☐ Adult correctional facility
☐ Halfway house
☐ Substance abuse treatment center
☐ Homeless / shelter
☐ 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:

☐ 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 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?

☐ Employed full or part time
☐ Extended Employment (a sheltered workshop)
☐ Self-Employment
☐ State Agency-Managed Business Enterprise Program (BEP)
☐ Unpaid family worker (family business or farm)
☐ Homemaker (care for home so another person in the household can earn income)
☐ Employment with supported employment services
☐ Not employed, attending college
☐ Not employed, attending high school or GED program
☐ Not employed, attending trainee, intern or volunteer
☐ Not employed, other

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	

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
List Tribe: _____
☐ Black / African American
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian
☐ Hawaiian
☐ Japanese
☐ Laotian
☐ Samoan
☐ Thai
☐ Vietnamese
☐ White / European American
☐ 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
☐ 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)
☐ 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?