

(03/17/2003)

DVR APPLICATION WORKSHEET
Cabinet for Workforce Development
Department of Vocational Rehabilitation

Caseload #: _____ Case # (S.S.) _____ Birth date: _____
Month/Day/Year

Name: _____
Last First MI Maiden

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

E-mail: _____ Telephone: _____ Referred date: _____
Month Day Year

Living Arrangement: _____ Homeless/Shelter ☐

Grade Level Completed: _____ Type of Degree/Certificate _____ Service under IEP: Yes ☐ No ☐

Gender: Male ☐ Female ☐ Race: _____ Referral by: _____

Last School Attended: _____ Date: _____

Primary Impairment: _____ Cause: _____

Secondary Impairment: _____ Cause: _____

Source of Support: _____ SSI Status: _____ SSDI Status: _____

Type of Public Support

None	SSI-A	SSI-B	SSI-D	TANF	GA	SSDI	VET-D	W-COMP	Other	Public Support Total
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Financial Assessment:

No. in Household & the Allowed Living Expense

1.....2221

6.....5638

2.....2904

7.....5766

3.....3673

8.....5894

4.....4271

9.....6022

5.....4954

10.....6150

(A) Total Number in Household _____

(B) Total Monthly Income _____

(C) Monthly Allowable Living
Expense (from chart) _____

(D) Monthly Income Available
for Rehab (B-C) _____

Work Status: _____

Hours Worked: _____ Hourly Earnings: _____ Weekly Earnings: _____

Type of Medical Insurance and Comparable Benefits: (Check block if yes)

Source	Y	Carrier ID #	Source	Y	Carrier ID #
Medicaid	<input type="checkbox"/>		Comm. Men. Health	<input type="checkbox"/>	
Medicare	<input type="checkbox"/>		PELL	<input type="checkbox"/>	
Health Insurance	<input type="checkbox"/>		Veteran's Admin.	<input type="checkbox"/>	
1. Private-Other	<input type="checkbox"/>		Workers Compensation	<input type="checkbox"/>	
2. Private Employer	<input type="checkbox"/>		Other	<input type="checkbox"/>	
3. Public-Other	<input type="checkbox"/>		Other	<input type="checkbox"/>	

Means of Transportation: _____ Driver's License ☐

Veteran: Yes ☐ No ☐

38. Applicant Vocational Preferences: _____

39. Work History Section:

Employer Name & Address: _____	Begin-End Dates: _____	Job Title: _____
Hourly Salary: _____	Hours Per Week: _____	Reason for Termination: _____
Job Functions: _____		

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Job Functions: _____		

40. Name, Address, Phone # of Contact Person: _____

41. Key Family Members (Name, Age, Relation, Occupation): _____

FOR COUNSELOR USE ONLY:

APPLICANT STATEMENT:

I understand that I will not be denied services on the basis of race, color, national origin, sex, age, religion, or type of disability. I understand the need for the Department of Vocational Rehabilitation to collect information about me and authorize release of any medical, psychological, educational or other information to the Department of Vocational Rehabilitation.			
I have been provided with a copy of the "Consumer Guide" which contains a written description of the program and my rights and responsibilities.			
The information I have given is true to the best of my knowledge and I hereby request Vocational Rehabilitation Services. I understand that my signature signifies my intent to work after completion of Vocational Rehabilitation Services.			
Signature: Counselor _____	Date _____	Signature: Individual _____	Date _____
Signature: Parent or Guardian _____	Date _____		