(10/01/2001)

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: _____ 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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Financial Assessment:

No. in Household & the Allowed Living Expense

1.....1759	6.....4465
2.....2300	7.....4566
3.....2909	8.....4668
4.....3382	9.....4769
5.....3923	10.....4870

(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			Comm. Men. Health		
Medicare			PELL		
Health Insurance			Veteran's Admin.		
1. Private-Other			Workers Compensation		
2. Private Employer			Other		
3. Public-Other			Other		

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: ______________________________
____

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