



State of Rhode Island and Providence Plantations
Department of Human Services
Office of Rehabilitation Services

40 Fountain Street ~ Providence, RI 02903
401-421-7005 ~ 401-222-3574 FAX
TDD (401) 421-7016 ~ Spanish (401) 462-7791

Thank you for your interest in services provided through the Office of Rehabilitation Services - Vocational Rehabilitation Program. The Vocational Rehabilitation Program is intended to help you obtain a job that matches your skills and interests.

In this packet you will find informational fact sheets about Vocational Rehabilitation services, voter registration, the Client Assistance Program (CAP), Informed Choice, etc.

Forms include the Application for VR Services, Health and Functional Capacities Self-Assessment, voter registration forms, etc.

Please **DO NOT SIGN** the Release Form/Authorization for Disclosure/Use of Health Information (ORS-37) form or other forms in packet until you meet with a Vocational Rehabilitation Counselor and complete them.

After you have completed pages 1-6, which include your Application (ORS-4) and Current Health and Functional Capacities Self-Assessment form (ORS-3), please sign, and mail JUST THESE TWO forms back to:

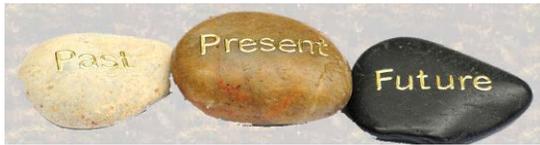
**Office of Rehabilitation Services
Attn: Intake
40 Fountain Street
Providence, RI 02903**

Please bring this packet with you when you meet with your counselor for the first time so that remaining forms can be completed and signed. We look forward to meeting with you to discuss the ORS Vocational Rehabilitation Program.

RHODE ISLAND OFFICE OF REHABILITATION SERVICES IS HERE FOR YOU IF:

- You have a documented disability
- You need services to obtain work, or retain your employment
- You want to work in a competitive job market in the Rhode Island/ local workforce
- You are ready to make some positive choices to get your life moving towards employment

"Life is a journey - not a destination. We determine our destiny by the direction we take."
~ Anonymous



ORS is here to assist YOU with taking charge of your life and meeting your employment goal!

Rhode Island Office of Rehabilitation Services provides services without regard to race, color, creed, religion, sex, disability, ancestry or national origin.

OFFICE OF REHABILITATION SERVICES CONSISTS OF:

Vocational Rehabilitation Unit: The focus of the Vocational Rehabilitation Program is to help people with disabilities prepare for, obtain and maintain employment

Services for the Blind and Visually Impaired Unit: The Services for the Blind and Visually Impaired unit offers a variety of training and adjustment services for individuals who are blind or who have significant visual impairments.

Disability Determination Services Unit: The Disability Determination Services unit determines the eligibility for children and adults with disabilities who are applying for cash benefits from the federal Social Security Administration's programs.

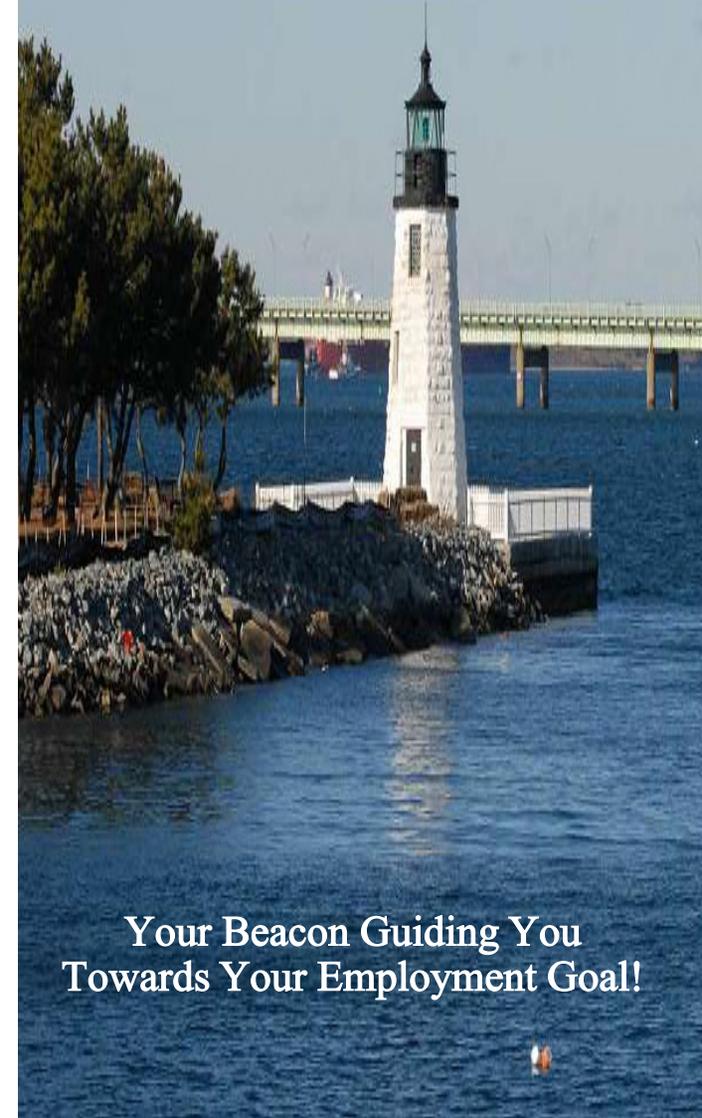


Department of Human Services/
Office of Rehabilitation Services
40 Fountain Street ~ Providence, RI 02903
(401) 421-7005 (V)
(401) 421-7016 (TDD)
(401) 462-7791 (Espanol)
www.ors.ri.gov

(Cover photo: Goat Island Lighthouse in Newport, RI)

Revised 6/2015

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES OFFICE OF REHABILITATION SERVICES



Your Beacon Guiding You
Towards Your Employment Goal!

VOCATIONAL REHABILITATION SERVICES

ASSISTING INDIVIDUALS WITH DISABILITIES TO CHOOSE, PREPARE FOR, OBTAIN AND MAINTAIN EMPLOYMENT, ECONOMIC SELF-SUFFICIENCY,
PERSONAL INDEPENDENCE AND FULL INCLUSION INTO SOCIETY

WHAT IS VOCATIONAL REHABILITATION (VR)?

Rhode Island Office of Rehabilitation Services is a leader in providing disability-related services to assist people with employment opportunities.

We are the state agency that helps people with disabilities to become employees in the competitive workforce.

AM I ELIGIBLE FOR VOCATIONAL REHABILITATION SERVICES?

- Do you want to work?
- Do you have a condition that limits your job opportunities, such as: physical, sensory, or emotional impairments?
- Do you require vocational rehabilitation services to prepare for, obtain, retain, or regain employment?

IF YOU ANSWERED YES, YOU SHOULD APPLY FOR VR SERVICES:

- Visit <http://www.ors.ri.gov/Forms/ApplicationORS.pdf> for an online application
- Call VR Intake at (401) 421-7005 or (401) 421-7016 (TDD) or
- Visit a netWORKri One-Stop Career Center and ask to talk with an Office of Rehabilitation Services Vocational Rehabilitation Counselor

IF YOU ARE FOUND ELIGIBLE:

- You will work in partnership with your ORS Vocational Rehabilitation Counselor to determine your Employment Goal based upon your impairment, work history, strengths, and abilities
- Your success relies on your active participation and engagement with your ORS Vocational Rehabilitation Counselor while working towards your employment goal

WHAT ARE SOME SERVICES I MAY RECEIVE THAT WILL BENEFIT ME?

- **Evaluations:** Medical, work-related, psychological, educational
- **Career Counseling:** Adjustment to disability, planning for the future, interest assessments, disability-related knowledge
- **Training:** On-the-Job (OJT), job coaching & post-secondary training
- **Employment:** Resumes, applications, interviewing skills, job placement assistance
- **Accommodations:** Personal support services, assistive technology, interpreters, readers, note takers, ADA, work-site evaluations
- **Transition Services for Students with Disabilities:** Individualized services are done in collaboration between schools and ORS
- **Benefits Counseling:** Provided to people who receive SSA disability benefits who want to understand how work impacts their SSI or SSDI



State of Rhode Island and Providence Plantations
 Department of Human Services/Office of Rehabilitation Services
 40 Fountain Street ~ Providence, RI 02903 ~ 401.421.7005 (V)
 401.421.7016 (TDD) ~ 401.462-7791 (Spanish) ~ 401.222-3574 (Fax)
www.ors.ri.gov

ORS Use
 Region:
 Area:
 ORS-4 Rev. 04/2014

“Assisting eligible individuals with disabilities to choose, prepare for, obtain and maintain employment.”

Application & Initial Information for the Vocational Rehabilitation (VR) Program

Please fill out this application to the best of your ability. If you do not feel comfortable disclosing some of the information, you can complete the application when you meet with an ORS Counselor.

Do you speak English? Y ___ N ___ If no, what is the primary language spoken? _____

Name: _____
 (Last) (First) (Middle Initial)

Address: _____ Phone: _____

City/Town: _____ Zip: _____ Cell/Video Relay: _____

Date of Birth: _____ Sex: ___ Veteran: Y ___ N ___ E-mail Address: _____

Social Security #: _____ Emergency Contact: _____

Have You Previously Applied for VR Services: Y ___ N ___ Previous Name: _____

Do you receive SSI and/or SSDI and intend to work? SSI ___ SSDI ___ (**Attach award letter, if available.**)

What is your disability? _____

Have you received a Ticket to Work? Y ___ N ___ Do you have transportation available to you? Y ___ N ___

What is your employment or career goal(s)? _____

How did you learn about VR? Who referred you? _____

**I am applying for Vocational Rehabilitation Services because I want to work,
 or maintain employment if I am employed.**

Signature: _____ Date: _____
 Parent or Guardian (if applicable) _____ Date: _____

Do you want to register to vote? Y ___ N ___ Have you ever been convicted of a felony? Y ___ N ___

Your assistance in providing the information requested on the following pages will help speed up your eligibility and employment plan process. A Vocational Rehabilitation Representative can assist you in completing the information if you wish. Please contact (401) 421-7005 (Intake) or (401) 421-7016 (TTY), if you need assistance to complete the form. En Espanol, (401) 272-8090.

(Over)

WORK & EDUCATIONAL EXPERIENCE

WORK HISTORY (Most recent first or attach resume)

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason for Leaving Job: _____

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

EDUCATION & TRAINING

Highest Grade Completed: _____ Special Education [IEP]: Y ___ N ___ Diploma: Y ___ N ___ GED: Y ___ N ___

Did you receive support services in school? Y ___ N ___ Describe (e.g. technology, aide, etc.): _____

High School: _____ College: _____

Degree Obtained: _____ Year: _____

Other Training: _____

Skills/Hobbies (e.g. languages, computer, skills, licenses, volunteer experience, etc.): _____

INFORMATION ABOUT YOUR DISABILITY

DISABILITY/MEDICAL CONDITION (What prevents you from working?)

Describe your limitations to employment: _____

Medical condition (if known): _____

PHYSICIANS/HOSPITAL/CLINIC

Dates of Service

Name(s) and Address: _____

MENTAL HEALTH/PSYCHOLOGIST/SOCIAL WORKER

Dates of Service

Name(s) and Address: _____

MEDICATIONS/TREATMENTS

Name/Type

Dosage/Frequency

MEDICAID Y __ N __

MEDICARE Y __ N __

PRIVATE Y __ N __

MEDICAL COVERAGE

Insurance/Benefit

Claim No.

Provided by Employer

EQUIPMENT NEEDED TO WORK _____

COUNSELOR'S COMMENTS: _____

DEMOGRAPHICS

Number of Persons in Household: _____ Number of Dependents: _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Check All That Apply: White ___ Black/African American ___ Asian ___
Native Hawaiian/Pacific Islander ___ American Indian/Alaskan Native ___

Ethnicity (Check one): Hispanic/Latino Yes ___ No ___

PUBLIC BENEFITS/INCOME

**(A financial needs test must be completed for many VR-purchased services.
The following income information will be helpful for your initial planning.)**

Cash, Savings and Other Liquid Assets \$ _____

GROSS INCOME

Amount (Wk./Mo./Yr.)

Wages/Salary _____	\$ _____
Social Security Insurance (SSI) _____	\$ _____
Social Security Disability Insurance (SSDI) _____	\$ _____
Family Independence Program (FIP)/ RIWorks _____	\$ _____
Temporary Disability Insurance (TDI) _____	\$ _____
Workers Compensation _____	\$ _____
Veterans Benefits _____	\$ _____
Unemployment Benefits _____	\$ _____
Private Disability Insurance _____	\$ _____
Pension or Annuity _____	\$ _____
Other Income _____	\$ _____

(Savings, including spousal income, rents, interest, etc.)

REHABILITATION EXPENSES (Non-Reimbursable)

WEEKLY AMT.

Medical _____	\$ _____
Rehabilitation/Adaptive Technology _____	\$ _____
Other Rehabilitation Needs _____	\$ _____

CERTIFICATION: (Complete once you have met with a VR Representative)

I have been provided with an explanation of the VR program, my rights and responsibilities, and I have been given a Client Assistance Program (CAP) brochure. I have been informed that I can appeal decisions, and I have been told how to do this. I have also been advised of the necessity to have all services pre-approved by my ORS Representative and to keep him/her informed of any changes in my situation whether, medical, financial, or otherwise. I certify that the information I give is true and complete to the best of my knowledge and belief, and I know that false or misleading statements or failure to report changes may result in prosecution for intent to defraud. I understand that the information given is CONFIDENTIAL, and it will be used only for purposes directly connected with the administration of the VR program.

I agree to notify my ORS Counselor when I become employed and allow ORS to access my wage records.

Signatures: _____

Applicant

Parent or Guardian (if applicable)

Date

Signature of Person who helped you complete application: _____ Phone: _____

Vocational Rehabilitation Counselor: _____



**DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TTY)**

“Helping individuals with disabilities to choose, find and keep employment”

**CURRENT HEALTH AND FUNCTIONAL CAPACITIES
SELF-ASSESSMENT**

Name: _____ Date: _____

Height: _____ Weight: _____ D.O.B.: _____ SS#: _____

Please list the most important problem(s) that interfere with your working: _____

For each area below, choose whether you have EXCELLENT or AVERAGE health or ability in that area or whether you have some problems. This is important information in planning for work.

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
HEARING				
SEEING				
SPEAKING				
SITTING				
STANDING				
WALKING				
KNEELING				
BENDING				
LIFTING				
PUSHING/PULLING				
HANDLING/FINGERING/FEELING				
CLIMBING				
BALANCING				
COORDINATION				
STRENGTH				
ENERGY/STAMINA				
BREATHING				
ALLERGIES				
REMEMBERING				
LEARNING				
READING				
WRITING				
CONCENTRATING				

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
MAKING DECISIONS				
SOLVING PROBLEMS				
GETTING ORGANIZED				
COLD/HOT WEATHER				
GROOMING/SELF CARE				
PEOPLE (GETTING ALONG WITH OTHERS)				
NERVOUSNESS/ANXIETY				
DEPRESSION				
MEALS/DIGESTION				
TAKING MEDICATIONS				
USING TRANSPORTATION				
USING ADAPTIVE EQUIPMENT				
JOB SKILLS				
HOW TO FIND AND GET JOBS				
WORK HABITS				
BEING RELIABLE/DEPENDABLE				
WORK RECORD				
OTHER (PLEASE LIST				

How often have you been hospitalized in the last two years? _____

Do you use? () Tobacco () Alcohol () Other Drugs If yes, how much? _____

Do you have a history of dependency on? () Drugs () Alcohol

If so, what is the date of your sobriety? _____

In planning for work, how concerned are you about loss of SSI/SSDI benefits? _____

This is the best estimate of my abilities and limitations.

Signature



Notice to Applicant Registering to Vote in Rhode Island

The State Board of elections urges all of its citizens to register to vote. Your vote will benefit you and your family.

Included in this packet of forms is a voter registration form. If you would to register to vote, complete and sign the form and mail it to your local Board of Canvassers. (directory listed on the back of the form)

Register to vote

- If you are not registered to vote where you live today, complete the enclosed form.
- Applying to register or declining to register to vote will not affect the amount of assistance provided by this agency.
- If you would like help in completing the voter registration application form, you can bring it with you when you return the other completed forms in this package, or go to the local Board of Canvassers in the city/town where you live. (City/Town directory is on the back of the voter registration form.) The decision whether to seek or accept help is yours.
- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.



State of Rhode Island Agency Voter Registration Certification

The State of Rhode Island urges all of its citizens to register to vote. Your vote will benefit you and your family. Thank you for taking the time to fill out this important form.

Register To Vote

If you are not registered to vote where you live now, would you like to apply to register to vote here? Where you submit your registration form is confidential.

- Yes, I would like to register to vote. (Please fill out the voter registration form)
- No, I do not want to register to vote, or I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote, or I am taking the voter registration form with me and may complete the voter registration form and send it in at a later time.

IF YOU DO NOT CHECK EITHER BOX YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

- If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.
- Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.
- You may leave the voter registration form at the office where you received it, or you may mail or deliver it to the Board of Canvassers in your city/town hall.
- If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, Rhode Island Board of Elections, 50 Branch Avenue, Providence, R.I. 02904 or (401) 222-2345.

Applicant's Signature

Print Name

Date

For Agency Use Only

- Check here if client refuses to sign. (Print the client's name on the "Print Name" line above.)

Registration Agent's Initials

Date

This form must be retained by the agency for 24 months.



RHODE ISLAND VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.
(You must be at least 18 years of age to vote on Election Day.)

INSTRUCTIONS

Box 2: REQUIRED. Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

Box 3: If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification on an election official before voting. Acceptable forms of identification are on the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side of this form).

Box 5: A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

Box 9: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 10: You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

Box 11: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

Box 12: If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

1. Check Boxes that Apply: <input type="checkbox"/> New Voter Registration <input type="checkbox"/> Address Change <input type="checkbox"/> Party Change <input type="checkbox"/> Name Change				
2. I am a U.S. Citizen and resident of Rhode Island. <input type="checkbox"/> Yes <input type="checkbox"/> No		3. RI driver's license or ID Number: <input style="width: 150px;" type="text"/>		
I am at least 16 years of age. (You must be at least 18 years of age to vote.) <input type="checkbox"/> Yes <input type="checkbox"/> No		If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: <input style="width: 80px;" type="text"/>		
If you checked NO to either of these statements, do not complete this form.				
4. Last Name <input style="width: 150px;" type="text"/>		Suffix (if any) <input style="width: 80px;" type="text"/>	First Name <input style="width: 150px;" type="text"/>	
			Middle Name (or initial) <input style="width: 100px;" type="text"/>	
5. Home Address (Do not enter a post office box) <input style="width: 150px;" type="text"/>			Apt. <input style="width: 40px;" type="text"/>	City/Town <input style="width: 100px;" type="text"/>
				State RI
				ZIP Code <input style="width: 60px;" type="text"/>
6. Mailing Address (If different from Box 5) <input style="width: 150px;" type="text"/>			Apt. <input style="width: 40px;" type="text"/>	City/Town <input style="width: 100px;" type="text"/>
				State <input style="width: 40px;" type="text"/>
				ZIP Code <input style="width: 60px;" type="text"/>
7. Date of Birth (mm/dd/yyyy) <input style="width: 100px;" type="text"/>		8. Phone No./ E-mail Address (optional) <input style="width: 150px;" type="text"/>		9. Party Affiliation: <input type="checkbox"/> Democrat <input type="checkbox"/> Moderate
Month Day Year				<input type="checkbox"/> Republican <input type="checkbox"/> Unaffiliated <input type="checkbox"/> Other <input style="width: 50px;" type="text"/>
10. I swear or affirm that: - I am not incarcerated in a correctional facility upon a felony conviction. - I am not presently judged "mentally incompetent" to vote by a court of law. - The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.				<i>Official Use For Barcode</i>
PLEASE SIGN FULL NAME OR PLACE MARK BELOW				
<input style="width: 150px; height: 30px;" type="text"/>				Are you interested in working at the polls? (check box below) <input type="checkbox"/>
				Date: <input style="width: 100px;" type="text"/> (mm/dd/yyyy) Signed
Warning: If you sign this form and know it to be false, you can be convicted and fined up to \$5,000 or jailed up to 10 years.				
11. PREVIOUS NAME (if different from Box 4) <input style="width: 150px;" type="text"/>			12. PREVIOUS ADDRESS OF REGISTRATION (City/Town, State, ZIP & County) <input style="width: 150px;" type="text"/>	

Return Address



Postage Required Post Office will not deliver without proper postage.

Mail To: **BOARD OF CANVASSERS**

*****FOLD HERE & TAPE AT TOP*****

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

- 1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "Mail To: BOARD OF CANVASSERS" on the addressed side of the voter registration form. Insert your return address in the space provided.

NOTICE: It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.

LOCAL BOARDS OF CANVASSERS

- Barrington Town Hall, 283 County Rd., Barrington, RI 02806
Bristol Town Hall, 10 Court St., Bristol, RI 02809
Burrillville Town Hall, 105 Harrisville Main St., Harrisville, RI 02830
Central Falls City Hall, 580 Broad St., Central Falls, RI 02863
Charlestown Town Hall, 4540 S. County Trail, Charlestown, RI 02813
Coventry Town Hall, 1670 Flat River Rd., Coventry, RI 02816
Cranston City Hall, 869 Park Ave., Cranston, RI 02910
Cumberland Town Hall, 45 Broad St., Cumberland, RI 02864
East Greenwich Town Hall, PO Box 111, East Greenwich, RI 02818
East Providence City Hall, 145 Taunton Ave., East Providence, RI 02914
Exeter Town Hall, 675 Ten Rod Rd., Exeter, RI 02822
Foster Town Hall, 181 Howard Hill Rd., Foster, RI 02825
Glocester Town Hall 1145 Putnam Pike PO Drawer B, Glocester, RI 02814
Hopkinton Town Hall, 1 Town House Rd., Hopkinton, RI 02833
Jamestown Town Hall, 93 Narragansett Ave., Jamestown, RI 02835
Johnston Town Hall, 1385 Hartford Ave., Johnston, RI 02919
Lincoln Town Hall, 100 Old River Rd., PO Box 100, Lincoln, RI 02865
Little Compton Town Hall, PO Box 226, Little Compton, RI 02837
Middletown Town Hall, 350 East Main Rd., Middletown, RI 02842
Narragansett Town Hall, 25 Fifth Ave., Narragansett, RI 02882
New Shoreham Town Hall, PO Drawer, 220 Block Island, RI 02807
Newport City Hall, 43 Broadway, Newport, RI 02840
N. Kingstown Town Hall, 80 Boston Neck Rd., North Kingstown, RI 02852
North Providence Town Hall, 2000 Smith St., North Providence, RI 02911
North Smithfield Municipal Annex, 575 Smithfield Rd., North Smithfield, RI 02896
Pawtucket City Hall, 137 Roosevelt Ave., Pawtucket, RI 02860
Portsmouth Town Hall, 2200 East Main Rd., Portsmouth, RI 02871
Providence City Hall, 25 Dorrance St., Providence, RI 02903
Richmond Town Hall, 5 Richmond Townhouse Rd., Wyoming, RI 02898
Scituate Town Hall, PO Box 328, North Scituate, RI 02857
Smithfield Town Hall, 64 Farnum Pike, Smithfield, RI 02917
S. Kingstown Town Hall, 180 High St., Wakefield, RI 02879
Tiverton Town Hall, 343 Highland Rd., Tiverton, RI 02878
Warren Town Hall, 514 Main St., Warren, RI 02885
Warwick City Hall, 3275 Post Rd., Warwick, RI 02886
W. Greenwich Town Hall 280 Victory Highway, W. Greenwich, RI 02817
West Warwick Town Hall, 1170 Main St., West Warwick, RI 02893
Westerly Town Hall, 45 Broad St., Westerly, RI 02891
Woonsocket City Hall, P.O. Box B, 169 Main St., Woonsocket, RI 02895

Voter Registration Questions May Be Addressed To:

Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov



**RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES**

“Helping individuals with disabilities to choose, find and keep employment”

ELIGIBILITY

To be eligible for Vocational Rehabilitation services, every individual must meet the following criteria:

1. the individual must have a physical, intellectual or emotional impairment
2. which causes a substantial barrier to employment, and
3. the individual must be able to benefit from vocational rehabilitation services (this is usually presumed), and
4. need vocational rehabilitation services in order to achieve employment.

ORDER OF SELECTION

Whenever the state Vocational Rehabilitation agency does not have enough resources to help everyone who is eligible for services, a priority system must be used. This system is called an **Order of Selection**. In Rhode Island, there are three (3) priority categories.

The three (3) priority categories are defined by the severity of an individual’s disability, including how many life areas are limited as a result of the disability. There are seven (7) life areas which may be limited by a disability: **mobility, communication interpersonal skills, self-care, self-direction, work skills and work tolerance.**

PRIORITY CATEGORIES

1. Individuals with the **most significant disabilities** – three (3) or more life areas are affected by the disability and multiple services are needed for an extended period of time in order for the individual to work;
2. Individuals with **significant disabilities** – one (1) life area is seriously affected by the disability and multiple services are needed for an extended period of time (***at least 6 months***) in order for the individual to work;
3. All other individuals with disabilities.



DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES

“Helping individuals with disabilities to choose, find and keep employment”

Informed Choice in Employment Planning

Informed choice means making choices based on accurate information and knowledge. These choices are based on a partnership between the individual with a disability and the Vocational Rehabilitation Counselor. The purpose is to successfully choose, find and keep employment.

Important Choices In Your Employment Planning

- Your Employment Goal
- What Services And Supports Are Needed To Reach Your Employment Goal
- Who Will Provide The Services And Supports
- How Will The Services And Supports Be Provided

Your Role In Making Informed Choices

- Learn About Yourself
- Gather And Understand Information
- Ask Questions
- Learn About And Understand Your Choices
- Clearly Communicate With Your Vocational Rehabilitation Counselor
- Make Your Decisions Based on Information Gathered
- Set Your Goals
- Follow Through With Your Choices
- Stay In Contact With Your Vocational Rehabilitation Counselor

Your Vocational Rehabilitation Counselor’s Role in Informed Choice

- Help You To Find Information
- Help You To Understand Information
- Help You To Look At Several Choices
- Refer You To Other People Who Might Help

If you have difficulty making informed choices, discuss this with
your Vocational Rehabilitation Counselor.



Rhode Island Disability Law Center, Inc.

275 Westminster Street, Providence, RI 02903

« The Designated Protection and Advocacy System for Rhode Island (formerly RIPAS) »

(401) 831-3150 Voice
(401) 831-5335 TTY
(401) 274-5568 FAX
(800) 733-5332 Clients

THE CLIENT ASSISTANCE PROGRAM "CAP"

We provide free legal help to individuals with disabilities applying for or receiving services from the Office of Rehabilitation Services (Vocational Rehabilitation and Services for the Blind and Visually Impaired) and Independent Living Services if they have a dispute regarding eligibility and/or provision of services.

You have the right to:

- Be presumed eligible if you are receiving Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI). You have the right to an eligibility determination within 60 days of your application for services (Vocational Rehabilitation and Services for the Blind and Visually Impaired).
- Be a partner in the development of goals and services.
- Receive written notice of important decisions made in your case, including notice of your appeal rights.
- Not be discriminated against in the provision of services regardless of the nature or severity of your disability.
- Receive timely responses to your inquiries to your Rehabilitation Counselor.
- Be represented in any Office of Rehabilitation Services mediation or appeals process.

PLEASE CALL US IF WE CAN BE OF ASSISTANCE

831-3150 Voice
831-5335 TTY
(800) 733-5332 Toll Free



Rhode Island Department of Human Services
600 New London Avenue
Cranston, RI 02920-3024

HIPAA-1 (Eff. 09/13)

NOTICE OF PRIVACY PRACTICES

(Notice)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Our Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the delivery of health care to you, or the payment for the health care is considered "Protected Health Information" (PHI).

We are required by law to follow the privacy practices described in this Notice, although **we reserve the right to change our privacy practices and the terms of this Notice at any time**. We will post any changes to our Notice on our Rhode Island Department of Human Services web site located at <http://www.dhs.ri.gov> where you may also obtain more detailed information regarding each of the topics addressed in our Notice. You may also request a hard copy of our Notice by calling the Privacy Officer at 401-462-1879 or writing Ralph Bacca, Privacy Officer, 74 West Road, Hazard Bldg. 1-7, Cranston, RI 02920.

2. How We May Use and Disclose Your Protected Health Information.

Generally, we are permitted to use and/or disclose your PHI for your **Treatment**, the **Payment** for services you receive, and for our normal health care **Operations (TPO)**. For most other uses and/or disclosure of your PHI, you will be asked to grant your permission via a signed Authorization. However, we are permitted to make certain other uses and/or disclosures of your PHI without your authorization. Uses and/or disclosures are permitted as follows:

◆ **Uses and/or disclosures related to your treatment, our payment, or our health care operations (TPO):**

For treatment (T): We may exchange your PHI with your doctor, dentist, or other healthcare provider to make sure you receive proper care.

For payment (P): We may exchange your PHI with Medicare or other health insurance plans you may have to make sure the treatment you receive is paid for.

For health care operations (O): We may exchange your PHI with other Business Associates and health care review organizations to make policy decisions that could affect you and others enrolled in DHS Programs.

Appointment reminders: Unless you request that we contact you by other means, we are permitted to send appointment reminders and other similar materials to your address.

◆ **Uses and/or disclosures requiring your Authorization:** Generally, most uses and/or disclosures of your PHI for purposes other than TPO will require your signed Authorization. You retain the right to revoke your Authorization at any time except to the extent that we have already undertaken an action in reliance upon your Authorization.

◆ **Uses and/or disclosures not requiring your Authorization:**

➤ **When required by law to:**

- Report abuse, neglect or domestic violence
- Public health activities
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement activities
- Coroners, medical examiners and funeral directors about decedents
- For medical research purposes
- Prevent a serious threat to health or safety
- For specific government functions and national security reasons
- Military & Veteran activities deemed necessary by Armed Forces
- Inmates and Correctional Institutions
- Workers' Compensation
- Organ and Tissue Donation organizations

◆ **Uses and Disclosures requiring you to have an Opportunity to Object:**

- To families, friends or others involved in your care

3. Your Rights Regarding Your Protected Health Information (PHI).

- Right to request restrictions on PHI uses and/or disclosures
- Right to request confidential communications
- Right to access and copy your PHI
- Right to request amendment of your PHI
- Right to an accounting of disclosures of your PHI
- Right to receive written notification of a breach
- Right to have someone act on your behalf
- Right to obtain a hard copy of notices
- Right to file a complaint

4. How to Complain about our Privacy Practices.

If you believe that we may have violated your individual privacy rights, you may submit your written complaint to our Privacy Compliance Officer at the address provide in this paragraph. Your written complaint must name the entity that is the subject of your complaint and describe the acts and/or omissions you believe to be in violation of the Rule or of the provisions outlined in our Notice of Privacy Practices. If you prefer, you may file your complaint directly with the Secretary of the U.S. Department of Health and Human Services (Secretary). However, any complaint you file must be received by us, or filed with the Secretary, within 180 days of when you knew, or should have known, the act or omission occurred. We will take no retaliatory action against you if you make such complaints. If you wish to file any complaints, please forward your written correspondence to:

**RI Department of Human Services
HIPAA/Privacy Compliance Officer
74 West Road, Hazard Building 1-7
Cranston, RI 02920
(401) 462-1879 – Telephone
(401) 462-6239 – TTY (or 711) For Hearing Impaired
(401) 462-6165 – Fax**

5. Effective Date: This Notice is effective September 1, 2013.



**RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES**

“Helping individuals with disabilities to choose, find and keep employment”

ELIGIBILITY/ORDER OF SELECTION CHECKLIST

NAME: _____ SS #: _____

DISABILITY: _____ SECONDARY DISABILITY: _____

VERIFIED BY: __ MEDICAL/SCHOOL RECORDS __ APPLICANT’S STATEMENTS __ COUNSELOR OBSERVATIONS

	LIMITATION	YES	NO	IMPEDIMENT TO EMPLOYMENT
MOBILITY	Drive			Needs adaptation or training to drive, unable to drive
				Cannot travel in unfamiliar places alone
				Need modified vehicle to travel
	Use Bus			Unable to use public transportation independently
	Walk			Needs adaptive equipment for ambulation
				Unable to walk 100 yards w/o pausing to rest
	Climb			Unable to climb a flight of stairs
	Other			
COMMUNICATION	Hearing			Cannot hear or understand meaning of ordinary spoken conversation
				Needs specialized equipment/interpreter to communicate
	Speaking			Speech is unintelligible, difficult to understand
				Talks excessively, interrupts, intrudes inappropriately
				Needs specialized equipment/interpreter to communicate
	Reading			Cannot read manuals, messages, rules, safety signs
	Writing			Cannot take messages, notes
	Other			
INTER PERSONAL	Depression Anxiety			Social isolation/withdrawal/rejection, sudden shifts in mood and attitudes, low frustration tolerance, difficulty accepting supervisory monitoring or criticism
	Getting Along With Others			Poor peer relationships/interactions, poor eye contact. fails to understand obvious cues, unable to work with others in a team, unable to deal with conflict
	Other			
SELF CARE	Prepare Meals			Unable to cook, shop, plan menu
	Pay Bills			Unable to pay rent, utilities, etc., trouble handling money
	Grooming			Needs assistance with personal grooming, poor hygiene
	Taking Medications			Needs assistance administering medication, forgetting to take prescribed medication may lead to job problems
	Resources			Cannot contact resources for assistance when problems arise, not aware of available resources
	Other			

	LIMITATION	YES	NO	IMPEDIMENT TO EMPLOYMENT
SELF-DIRECTION	Impulsive			Places self at risk of accident by not thinking before acting, unable to work alone
	Solving Problems			Does not show initiative, frequently needs to be told what to do on the job
	Organization			Cannot devise plan to achieve goals, work site is disorganized
	Other			
WORK SKILLS	Job Skills			Cannot use previous skills because of disability, no job skills developed, slow work rate, requires additional time to learn new tasks, difficulty accepting direction from supervisor
	Work Habits			Poor attendance, often late, does not call in, disability causes person to lose time from work, poor concentration
	Work Record			Poor references, frequent job changes, long-term unemployment, no work history
	Organized			Needs help with organization, work area is disorganized
	Other			
WORK TOLERANCE	Sitting			Cannot sit for long periods
	Standing			Cannot stand for extended period of time
	Bending			Cannot bend to pick up work products from lower level
	Lifting			Cannot lift over _____ pounds
	Push/Pull			Cannot push or pull objects
	Handling, Fingering			Cannot do work requiring extensive fine finger dexterity, cannot successfully work on an assembly line
	Balance			Poor balance poses a risk in some environments
	Coordination			Poor motor coordination, clumsiness, eye-hand-foot movements are slower than average
	Energy/Stamina			Tires easily, cannot sustain a full work day
	Breathing/Allergies			Difficulty with exertion, cannot be exposed to dust/air pollutants/chemicals/fumes
	Vision			Difficulty perceiving differences in shapes and sizes in objects or graphic material. Inability to perceive pertinent detail with words and numbers and observe differences
	Other			

This is my best estimate of my abilities and limitations _____
Customer Signature (Required) _____ Date _____

Eligibility: Individual has a SEVERE NON SEVERE disability which results in significant functional limitations in ___ areas. Individual requires VR Services for employment. This individual is classified as a **Category** _____ in the **Order of Selection**. Services required are expected to include: _____

Counselor Signature _____ Date _____



DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES

40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TDD) ~ 401.222.3583 (Fax)

“Helping individuals with disabilities to choose, find and keep employment”

ORIENTATION CHECKLIST as of June 1, 2010

Applicant: _____ **Date:** _____

Applicant met with ORS Representative on this date, and was given the opportunity to register to vote, which applicant **accepted** / **rejected** . Information was provided to the applicant about the VR program and process. The following topics were specifically addressed:

- The purpose of the program
- The method of determining eligibility/evaluation/60-day eligibility
- Explanation of the Order of Selection process and services provided to Category 1 individuals with disabilities. (This also applies to those individuals receiving SSI/SSDI.)
- Potential impact upon benefits provided by the other programs/Benefits Planning
- HIPAA/Notice of Privacy Practices
- Customers’ Right to:
 - be a partner in the Vocational Planning Process
 - choose services, providers and cities in which services will be provided (Informed Choice)
 - develop one’s own Individualized Plan for Employment (IPE)
 - written notice of decisions
 - confidentiality (limits include harm to self/others, court order, mandated reporting, intra-agency)
 - review ORS generated documents
 - appeal adverse decisions: Mediation, Impartial Hearing, Client Assistance Program (CAP)
- Customers’ Responsibility to:
 - keep all scheduled appointments
 - maintain communication, informing ORS of employment or other changes in status
 - cooperate and work toward agreed upon goals in IPE
 - use comparable benefits (cost share if able to do so)
 - notify your counselor when you obtain employment
- Explanation of services – Assessment, counseling & guidance, training, job preparation activities, work experiences in integrated setting, job placement and retention services, therapeutic treatment, corrective surgery, assistive technology services and devices. **All services must be pre-authorized by your ORS Counselor.**
- Closure criteria
- Post-Employment Services
- Non-Discrimination clause
- Information you provide to your ORS Representative or Vocational Rehabilitation Counselor may be shared with your Department of Human Services RIWorks Caseworker and/or Disability Determination worker.

I, _____, received an explanation of the above and understand the information provided. I was given the opportunity to ask questions. I have signed the application for services.

_____ *Customer Signature* _____ *Date*

_____ *Vocational Rehabilitation Counselor* _____ *Date*

<input type="checkbox"/> Copy in Record	<input type="checkbox"/> Copy to Customer
---	---



DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES

40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TDD) ~ 401.222.3583 (Fax)

“Helping individuals with disabilities to choose, find and keep employment”

ORIENTATION CHECKLIST as of June 1, 2010

Applicant: _____ Date: _____

Applicant met with ORS Representative on this date, and was given the opportunity to register to vote, which applicant accepted [] / rejected []. Information was provided to the applicant about the VR program and process. The following topics were specifically addressed:

- The purpose of the program
The method of determining eligibility/evaluation/60-day eligibility
Explanation of the Order of Selection process and services provided to Category 1 individuals with disabilities. (This also applies to those individuals receiving SSI/SSDI.)
Potential impact upon benefits provided by the other programs/Benefits Planning
HIPAA/Notice of Privacy Practices
Customers’ Right to:
o be a partner in the Vocational Planning Process
o choose services, providers and cities in which services will be provided (Informed Choice)
o develop one’s own Individualized Plan for Employment (IPE)
o written notice of decisions
o confidentiality (limits include harm to self/others, court order, mandated reporting, intra-agency)
o review ORS generated documents
o appeal adverse decisions: Mediation, Impartial Hearing, Client Assistance Program (CAP)
Customers’ Responsibility to:
o keep all scheduled appointments
o maintain communication, informing ORS of employment or other changes in status
o cooperate and work toward agreed upon goals in IPE
o use comparable benefits (cost share if able to do so)
o notify your counselor when you obtain employment
Explanation of services – Assessment, counseling & guidance, training, job preparation activities, work experiences in integrated setting, job placement and retention services, therapeutic treatment, corrective surgery, assistive technology services and devices. All services must be pre-authorized by your ORS Counselor.
Closure criteria
Post-Employment Services
Non-Discrimination clause
Information you provide to your ORS Representative or Vocational Rehabilitation Counselor may be shared with your Department of Human Services RIWorks Caseworker and/or Disability Determination worker.

I, _____, received an explanation of the above and understand the information provided. I was given the opportunity to ask questions. I have signed the application for services.

Customer Signature _____ Date _____

Vocational Rehabilitation Counselor _____ Date _____

Copy in Record [] Copy to Customer []



DEPARTMENT OF HUMAN SERVICES – OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ (401) 421-7016 (TTY)
“Helping individuals with disabilities to choose, find and keep employment”

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. *(Name of Client)*

My Date of Birth: ____ / ____ / ____

My Social Security Number: ____ - ____ - _____

II. My information is to be disclosed to/ provided by:

And is to be provided to/disclosed by:

Name of Person/Organization

Name of Person/Organization

Address

Address

City/ST/Zip

City/ST/Zip

III. The purpose or need for this release of information is:

- To obtain the information checked below that will assist me in vocational rehabilitation planning
- My own personal and private reasons
- Other (*specify*): _____

IV. The information to be disclosed from my health record: (check all of the boxes that apply)

- Vocational Medical Educational Social
- Financial Psychiatric/Psychological Other (*specify*): _____
- Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

Specific Information Needed: _____

Dates of Service: _____ to _____

I would also like the following sensitive information disclosed: (check the applicable box(es))

- Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment
- Sexually Transmitted Diseases

V. I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me.

(Enter if different from one year after the date below)

Signature of Client

Date

Signature of Authorized Representative

Relationship to the Client

Date

Instructions for Completing Form ORS-37

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.
2. Section I – print name of the client whose information is to be released.
3. Section II – print the name and address of the person or organization authorized to release and/or receive the information. Also, provide the name of the DHS/ORS representative, unit and address that will receive and/or release the information.
4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)
5. Section IV – check all of the boxes that apply.
 - a. Vocational, Medical, Educational, Social, Financial, Psychiatric/Psychological
 - b. Other (*specify*) – specific information identified by the client (e.g., billing, employee health)
 - c. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
 - d. Specific Information Needed – clearly identify the precise information to be disclosed.
 - e. Dates of Service – note the first and last date of service requested.
 - f. RELEASE OF SENSITIVE INFORMATION – check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases – patient must check the appropriate box!
6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.
7. Section V – Authorized Representative (e.g., parent, legal guardian, power of attorney)
8. A copy of the completed Form ORS-37 will be given to the client.



DEPARTMENT OF HUMAN SERVICES – OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ (401) 421-7016 (TTY)
“Helping individuals with disabilities to choose, find and keep employment”

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my record. *(Name of Client)*

My Date of Birth: ____ / ____ / ____

My Social Security Number: ____ - ____ - ____

II. My information is to be disclosed to/ provided by:

And is to be provided to/disclosed by:

Name of Person/Organization

Name of Person/Organization

Address

Address

City/ST/Zip

City/ST/Zip

III. The purpose or need for this release of information is:

- To obtain the information checked below that will assist me in vocational rehabilitation planning
- My own personal and private reasons
- Other (*specify*): _____

IV. The information to be disclosed from my health record: (check all of the boxes that apply)

- Vocational Medical Educational Social
- Financial Psychiatric/Psychological Other (*specify*): _____
- Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

Specific Information Needed: _____

Dates of Service: _____ to _____

I would also like the following sensitive information disclosed: (check the applicable box(es))

- Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment
- Sexually Transmitted Diseases

V. I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me.

(Enter if different from one year after the date below)

Signature of Client

Date

Signature of Authorized Representative

Relationship to the Client

Date



**DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TTY)**

“Helping individuals with disabilities to choose, find and keep employment”

Referral Form

DATE OF REFERRAL: _____

REFERRAL FROM: _____ **REFERRAL TO:** _____

CUSTOMER NAME: _____ **ADDRESS:** _____

TELEPHONE: _____ **GENDER:** Male ___ Female ___ **DOB:** _____

DISABILITY: _____

MEDICATIONS (if any): _____

PURPOSE OF REFERRAL: _____

REFERRAL EXPECTATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

TRANSPORTATION: Car (independent) ___ Car (dependent) ___ **RIDE** ___ Bus ___ Other _____

Does customer require handicapped accessible transportation: Yes ___ No ___ Maybe ___

LIVING SITUATION: _____ **CHILD CARE ISSUES:** Yes ___ No ___ Unknown ___

INCOME: SSI ___ SSDI ___ FIP ___ FAMILY ___ UNEMPLOYMENT ___ WORKER’S COMP ___ OTHER _____

Are benefits an issue? Yes ___ No ___ Unknown ___

WORK HISTORY:

EDUCATION: Highest Grade _____ GED _____ Special Education _____

Other Education or Training: _____

Reading Level: _____ Math Level: _____

TYPE OF EMPLOYMENT /GOAL: _____

LIMITATIONS/RESTRICTIONS: _____

OTHER ISSUES/CONCERNS: _____

