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)
RI Relay 711 ~ 401.462-7791 (Spanish) ~ 401.222-3574 (Fax)
www.ors.ri.gov

ORS Use
Region:
Area:
ORS-4 Rev. 10/2018

"Assisting eligible individuals with disabilities to choose, prepare for, obtain, advance in, and maintain employment."
"In partnership with American Job Center.

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.

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: ______________________

What is your disability?____

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

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

Do you receive SSI ☐ SSDI ☐ **(Attach award letter, if available.) Did you** receive a Ticket to Work? Yes ☐ No ☐

What transportation is available to you? Car ☐ Bus ☐ Other ☐

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

Race: (Check all that apply) White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐

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

Do you speak English? Y ☐ No ☐ If no, what is the primary language spoken? ____________________

Have you currently been unemployed for more than 27 consecutive weeks? Yes ☐ No ☐

Do you want to register to vote? Yes ☐ No ☐ Have you ever been convicted of a felony? Yes ☐ No ☐

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

Signature: ____________________________________ Date: ___________

Parent or Guardian (if applicable) ________________________ Date: ____________

Counselor receipt of application (ORS personnel only):________________________

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 RI Relay at 711, if you need assistance to complete the form.
En Espanol, (401) 462-7791.

(Over)

WORK HISTORY (Most recent job and attach resume)

Employer Name and Address: ____________________

How did you get this job? ____________________

Hrs. per Week: ______ Dates Employed: ____________-____________ Hourly Pay: ______________

Job Title/Skills: ____________________

Most Liked About Job: ____________________

Least Liked About Job: ____________________

Reason for Leaving Job: ____________________

EDUCATION & TRAINING

High School: ____________________ Highest Grade Completed: ____ Diploma: Y ☐ N ☐ Date:__________

Special Education Certification of Completion: Y ☐ N ☐ GED: Y ☐ N ☐ Date: ____________

Special Education [IEP/504]: Y ☐ N ☐ Support Services provided: (e.g. technology, aide, etc.): ________________

____

____

College: ____________________ Years Attended: _________ Degree Obtained: ________________

Other Skills/Trainings: ____________________

Certification(s) Obtained: ____________________(Date):__________________

____

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

Describe your limitations to employment: ____________________

____

____

Technology/Supports/Resources needed to work: ____________________

____

____

PHYSICIANS / HOSPITAL / MENTAL HEALTH / PSYCHOLOGIST / SOCIAL WORKER

PHYSICIANS/HOSPITAL/CLINIC	**Specialty**	**Dates Of Service**

Name(s) and Address: ____________________

____

____

____

MEDICATIONS/TREATMENTS	**Name/Type**	**Dosage/Frequency**

____

____

____

____

____

MEDICAL COVERAGE

Provider **Claim No.** **Provided by Employer**

____

____

MEDICAID Y ☐ N ☐ **MEDICARE** Y ☐ N ☐ **PRIVATE** Y ☐ N ☐ **OTHER** Y ☐ N ☐

PUBLIC BENEFITS/INCOME

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 ________________	$__________

Cash, Savings and Other Liquid Assets $____________________________

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

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) ~ RI Relay – 711

"Helping individuals with disabilities to choose, find, advance in, and keep employment"

CURRENT HEALTH AND FUNCTIONAL CAPACITIES SELF-ASSESSMENT

Please check the boxes that best fit

	AVERAGE	SOME PROBLEMS	COMMENTS
Using Transportation			
Walking			
Climbing			
Hearing			
Speaking/Conversing			
Reading			
Writing			
Mood/Attitude			
Stress			
Getting Along with Others			
Concentration			
Remembering			
Daily Life Routine			
Taking Medication			
Impulsivity			
Making Decisions			
Learning New Tasks			
Planning/Setting Goals			
Accepting Direction			
Punctuality			
Getting/Keeping a Job			
Sitting/Standing			
Bending			
Lifting/Pushing/Pulling			
Gripping/Holding Feeling			
Balance/Coordination			
Fatigue/Stamina			
Breathing/Allergies			
Vision			

Do you have any other barriers to employment not listed above? ______________________________

Have you been hospitalized in the last two years? __________

Do you use? Tobacco ☐ Alcohol ☐ Drugs ☐ If yes, how much? ______________________________

Do you have a history of dependency on? Alcohol ☐ Drugs ☐ Sobriety Date: ______________________

In planning for work, are you concerned with the loss of SSI/SSDI benefits? ______________________________

____

This is the best estimate of my abilities and limitations.

______________________________ ______________________

Signature Date