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)

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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