



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) ~ 401.272.8090 (Spanish) ~ 401.222-3574 (Fax)  
[www.ors.ri.gov](http://www.ors.ri.gov)

ORS Use  
 Region:  
 Area:  
 ORS-4 Rev. 06/09

*“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.*

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: \_\_\_\_\_

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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: \_\_\_\_\_

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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 \_\_\_ Not-Hispanic/Latino \_\_\_

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### PUBLIC BENEFITS/INCOME (Optional)

(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) _____	\$ _____
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 _____	\$ _____

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### 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”*

**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**

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## 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.



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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.

	<b>EXCELLENT HEALTH/ ABILITY</b>	<b>AVERAGE HEALTH/ ABILITY</b>	<b>SOME PROBLEMS</b>	<b>COMMENTS</b>
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				

	<b>EXCELLENT HEALTH/ ABILITY</b>	<b>AVERAGE HEALTH/ ABILITY</b>	<b>SOME PROBLEMS</b>	<b>COMMENTS</b>
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