USOR-4
(Rev. 8/04)

Utah State Office of Rehabilitation
VOCATIONAL REHABILITATION APPLICATION

PART I: Tell us about yourself.

1. Social Security Number	(Office use only) Case #: ________________
2. Legal Name (Last) (First) (Initial)	
Nickname	
3. Street Address: ________________ City: ________________ State: _________ ZIP: ______________ County: ________________	
4. Telephone: ______ - _____ - ______ Alternate Phone Number: ______ - _____ - _____ E-Mail Address:________________	
5. Birthdate (mm/dd/yy): _____/ _____/_____	Gender: ***(circle one)*** Male Female
6. Race/Ethnicity: ***(Circle all that apply)*** Black/African American — White American Indian/Native Alaskan — Asian Native Hawaiian/Pacific Islander — Hispanic/Latino	
7. Marital Status (circle): Married Never married Divorced Separated Widowed	Number of Dependent Children:
8. Who referred you to Rehabilitation?	
9. Please describe your physical or mental disability (impairment):	
10. Are you receiving Social Security Benefits as a result of your disability? Yes No If yes, do you receive **(Circle one)** SSDI ? SSI ? Both? If no, have you received either SSDI or SSI in the past? Yes No Are you a current applicant for disability based Social Security Benefits? Yes No Do you have a Ticket to Work? Yes No	
11. Have you been in military service? Yes No If yes, type of discharge ________________	
12. What is the highest grade you completed in school? ____________ Did you ever receive Special Education services in school? ***(circle one)*** Yes No	

13. What is your current Living Arrangement? ***(Circle one)***

Private residence (by yourself or with family or other person) — Substance abuse treatment center
Adult/Youth correctional facility — Mental Health facility
Community Residential/Group Home — Nursing home
Homeless shelter — Rehabilitation facility
Halfway House — Other________________________

14. Have you had Vocational Rehabilitation services in the past? ***(Circle one)*** Yes No

If yes, where? ____
When? ______________________________

15. Please provide the following information on your work history:

	Position	**Hrs. worked/week**	**Weekly Income**	**Date Started**	**Date/reason/ended**
Current Position	_____________	________	________	______	____________
Last Job	_____________	________	________	______	____________
Other Previous Job	_____________	________	________	______	____________

16. Are you receiving public income support? Yes No

(If yes, check which below & fill in amount)

____ Supplemental Security Income (SSI) for the aged, Blind, or disabled Amount: $_____________
____ Family Employment Program [TANF]) Amount: $_____________
____ General Assistance (GA) Amount: $_____________
____ Social Security Disability Income (SSDI) Amount: $_____________
____ Veteran's disability benefit Amount: $_____________
____ Workers Compensation Amount: $_____________
____ Other (list) _____________________________ Amount: $_____________

17. What is your main source of financial support at this time?

18. What is your current medical insurance coverage? ***(Circle all that apply)***

None Medicaid Medicare Workers Compensation
Private (through employer) Other private insurance

19. If you have medical insurance, what is the name of the insurance coverage/company?

20. Name of parent or guardian_____________________________Phone______________

Address____
Name of person who will know your address in case you move____________________
Address____Phone________________

21. Are you a citizen of the United States? Yes__ No __. If no, what type of visa do you have?

PART II: Tell us more about your disability or physical/mental impairment.

22. Was the disability caused by: ***(circle one)***

Accident Disease Birth Work Related Injury Other (explain)___________

23. When did the disability occur ***(month and year***)?

24. How does your disability keep you from working, or cause problems in your ability to maintain work?

25. List hospitals and/or clinics where you have received treatment related to your disability:

name:____________________	name:_____________________	name:___________________
address:__________________	address:___________________	address:_________________
_________________________	__________________________	_______________________
phone:____________________	phone: ____________________	phone:___________________
date(s) __________________	date(s) __________________	date(s) _________________

26. List doctors or therapists who are treating, or have treated, you for your disability:

name:____________________	name:_____________________	name:___________________
address:__________________	address:___________________	address:_________________
_________________________	__________________________	_______________________
phone:____________________	phone: ____________________	phone:___________________
date(s) __________________	date(s) __________________	date(s) _________________

27. List the medications you are taking, (if any):

28. Have you ever been a resident in an: **(circle all that apply)**

Inpatient treatment center?	Yes	No	Jail, Prison?	Yes	No
Psychiatric facility?	Yes	No	Correctional school?	Yes	No

If yes, please list:

Name ____Date(s)______________

Address ____Phone_______________

Are you currently on probation or parole? Yes No

If yes, please list:

Name ____Date(s)______________

Address ____Phone_______________

PART III: Tell us more about your education and training.

29. List the high school(s) and post high school(s) you have attended: GED? Yes No

School Name Address Dates Attended Date Graduated

1.____

2.____

3.____

30. Name(s) under which you were registered for school:

31.List any specialized or technical training you have:

32. Have you been awarded federal financial aid for school? No Yes

(if yes, how much? $________________)

Do you have a Guaranteed Student Loan or PELL grant in default? No Yes

(if yes, how much? ________________)

PART IV: Tell us more about your rehabilitation needs.

33. What assistance do you need to become employed, or maintain your employment?
34. List any special technology or equipment that you currently use (or need) to work (for example; wheelchair, artificial limb, hearing aid, etc.):

PART V: For use by counselor for notes, summary, instructions, etc.

____ __________
Application Reviewed and accepted by: Date:

Notes, summary, instructions:
____

____

____

____

Please return this form to:
____

____

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Part VI: Sign the application after reading the following information.

GATHERING INFORMATION TO DETERMINE ELIGIBILITY: The information contained in this application is true and correct to the best of my knowledge. Permission is granted to the Utah State Office of Rehabilitation to make whatever inquiries might be necessary to verify these statements including the sharing of information with the Department of Workforce Services. In applying for Vocational Rehabilitation Services, I understand there is a need to collect personal information. The authority to collect this information comes from Federal Regulation 34 CFR 361.38(a) (1)(iii).
I understand that collecting this information is necessary to determine eligibility and therefore is mandatory. Failure to provide requested information may result in a determination of not being eligible for Vocational Rehabilitation Services. I understand that my counselor has 60 days from the date I submit a complete application to determine eligibility, but that circumstances may arise where this information cannot be acquired within this time frame. I agree to sign a request to extend the time for determination of eligibility if I want to have the 60 days extended.

CONFIDENTIALITY: I understand that information concerning me is confidential and protected under State & Federal regulations as well as professional codes of ethics governing confidentiality. I recognize this information cannot be disclosed without my written consent, unless otherwise provided for in the State and Federal regulations. However, I understand that information about me may be released to appropriate agencies or individuals without my informed consent in order to accomplish my vocational rehabilitation plan and job placement goals and I understand these agencies and/or individuals will be made known to me. I authorize the exchange of information between the Utah State Office of Rehabilitation and other entities, including the Department of Workforce Services, only for the use of the Utah State Office of Rehabilitation as needed to determine eligibility and appropriate services and for the administration of their program.

IN CASE OF A PROBLEM: I understand that a Client Assistance Program (CAP) representative is available to act as my advisor and advocate at any time, and that I may call toll free (1-800-662-9080) to reach the Client Assistance Program (CAP) located at 205 North 400 West, Salt Lake City, Utah 84103.

I understand that I have the opportunity for a timely review of any determination by my rehabilitation counselor. If I am dissatisfied with the furnishing or denial of Vocational Rehabilitation services, I may request a written or verbal review of a determination to my counselor, the immediate supervisor, the District Director, or to:

Division of Rehabilitation Services
Administration Office
P.O. Box 144200
Salt Lake City, Utah 84114-4200

NO DISCRIMINATION: I understand that services in this program are provided without regard to sex, race, age, religion, color, or national origin according to Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act. The agency also assures that no group of individuals will be excluded or found ineligible solely on the basis of type of disability.

I understand that altering this application in any way will make it invalid and I have completed this application in its original form. I have read (or have had read to me) and understand and agree to the above.

____ ________________

Signature of Applicant/Representative **Date**

____ ________________

Parent Signature (if applicant is a minor) **Date**