Kansas
Department for Children and Families
Rehabilitation Services

Strong Families Make a Strong Kansas

Application for Vocational Rehabilitation Services

Is Vocational Rehabilitation the right program for you?

Some brief information about the Vocational Rehabilitation (VR) program might help you decide whether to apply for services.

- VR serves people with any type of permanent physical, intellectual or mental disability.
- VR is an employment program. The purpose of VR is to help Kansans with disabilities become employed. We may also be able to provide services to help you keep the job you already have if your disability is causing difficulties for you at work.
- You must apply for services and be found eligible in order to receive services. After you apply, our staff will determine if you have a disability that is a significant impediment to employment, and if you require VR services to become employed. You may be asked to provide additional information about your disability, medical services and employment history to help determine if you are eligible.
- If you are eligible for services, a counselor will work with you to develop an Individual Plan for Employment (IPE). The IPE will list your employment goal and the services you will receive. The counselor will help you look at your employment options so you can make informed choices about the type of work you want to seek.
- Services are individualized according to each eligible person's unique rehabilitation needs, disability and employment goal.
- You may be asked to help pay for some services if it is determined that you or your family have the financial resources to do so.

If you have a disability and you want to work, start your road to employment today by completing this application for VR services. If you need help to answer any of these questions, please ask VR staff for assistance.

Information about you

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ SOCIAL SECURITY NUMBER _____

PREVIOUS LAST NAMES USED, SUCH AS MAIDEN NAME OR MARRIED NAMES _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT) _____ CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ PHONE NUMBER _____ CELL PHONE NUMBER _____ COUNTY OF RESIDENCE _____

EMAIL ADDRESS _____ CONTACT PERSON'S NAME AND PHONE NUMBER (someone who would be able to give you a message) _____

GENDER

_____ MALE
_____ FEMALE

MARITAL STATUS

_____ SINGLE
_____ MARRIED
_____ SEPARATED
_____ DIVORCED
_____ WIDOWED

RACE

_____ WHITE
_____ BLACK OR AFRICAN AMERICAN
_____ AMERICAN INDIAN OR ALASKA NATIVE
_____ ASIAN
_____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

U.S. CITIZEN

_____ YES _____ NO

IF NO, DO YOU HAVE AN ALIEN REGISTRATION CARD?

_____ YES _____ NO

IF NO, DO YOU HAVE AN EMPLOYMENT AUTHORIZATION DOCUMENT?

_____ YES _____ NO

YOU MUST HAVE A VISA WHICH ALLOWS EMPLOYMENT IN THE COMPETITIVE MARKETPLACE TO BE ELIGIBLE FOR SERVICES.

HISPANIC

_____ YES
_____ NO

U.S. MILITARY VETERAN

_____ YES
_____ NO

PRIMARY DISABILITY

What is the primary medical condition, injury, physical/mental impairment or disability that limits your ability to work? List or describe.

When did this disability begin (year)? _____

SECONDARY DISABILITY

Please list any other conditions, impairments or disabilities that limit your ability to work.

When did these conditions/disabilities begin (year)? _____

HIGHEST LEVEL OF EDUCATION (CHECK ONE)

_____ NO FORMAL SCHOOLING
_____ ELEMENTARY (GRADES 1-8)
_____ SOME HIGH SCHOOL BUT NO DIPLOMA (GRADES 9-12)
_____ SPECIAL EDUCATION CERTIFICATE/DIPLOMA OR CERTIFICATE OF ATTENDANCE
_____ HIGH SCHOOL GRADUATE OR GED
_____ SOME UNIVERSITY, COLLEGE OR TECH COLLEGE BUT NO DEGREE OR CERTIFICATE
_____ ASSOCIATE DEGREE
_____ BACHELOR'S DEGREE
_____ MASTER'S DEGREE
_____ DEGREE ABOVE MASTER'S, SUCH AS PH.D., ED.D., J.D.
_____ VOCATIONAL/TECHNICAL CERTIFICATE
_____ OCCUPATIONAL CREDENTIAL BEYOND UNDERGRADUATE
_____ OCCUPATIONAL CREDENTIAL BEYOND GRADUATE

CURRENT LIVING ARRANGEMENT (CHECK ONE)

_____ PRIVATE RESIDENCE (ON YOUR OWN, WITH YOUR FAMILY OR WITH A ROOMMATE)
_____ GROUP HOME
_____ REHABILITATION FACILITY
_____ MENTAL HEALTH FACILITY
_____ NURSING HOME
_____ JAIL OR CORRECTIONAL FACILITY
_____ HALFWAY HOUSE
_____ SUBSTANCE ABUSE TREATMENT CENTER
_____ HOMELESS/SHELTER
_____ OTHER

ARE YOU A STUDENT IN HIGH SCHOOL AT THE TIME OF THIS APPLICATION?

_____ NO, I'M NOT A HIGH SCHOOL STUDENT AT THIS TIME.
_____ YES, I'M IN HIGH SCHOOL AND I HAVE A 504 ACCOMMODATION PLAN.
_____ YES, I'M IN HIGH SCHOOL AND I'M RECEIVING SERVICES THROUGH AN INDIVIDUAL EDUCATION PLAN (IEP).
_____ YES, I'M CURRENTLY A HIGH SCHOOL STUDENT, BUT I DO NOT HAVE EITHER A 504 PLAN OR AN IEP.

WHO REFERRED YOU TO VR? (CHECK ONE)

_____ GRADE SCHOOL OR HIGH SCHOOL
_____ UNIVERSITY, COLLEGE OR TECHNICAL COLLEGE
_____ DOCTOR OR HOSPITAL (PUBLIC OR PRIVATE)
_____ MEDICAID (KANCARE, HEALTHWAVE, WORKING HEALTHY, WORK, MANAGED CARE ORGANIZATIONS)
_____ ECONOMIC AND EMPLOYMENT SERVICES
_____ CHILD SUPPORT SERVICES
_____ A REHABILITATION PROGRAM IN YOUR COMMUNITY
_____ SOCIAL SECURITY ADMINISTRATION OR DISABILITY DETERMINATION SERVICES
_____ ONE-STOP EMPLOYMENT/TRAINING CENTER (KANSASWORKS)
_____ SELF REFERRAL
_____ OTHER SOURCES
_____ AMERICAN INDIAN VR SERVICES PROGRAM
_____ CENTER FOR INDEPENDENT LIVING
_____ CHILD PROTECTIVE SERVICES
_____ CONSUMER ORGANIZATIONS OR ADVOCACY GROUP
_____ EMPLOYER
_____ FAITH BASED ORGANIZATION
_____ FAMILY OR FRIENDS
_____ INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SERVICE PROVIDER
_____ MENTAL HEALTH PROVIDER (PUBLIC OR PRIVATE)
_____ PUBLIC HOUSING AUTHORITY
_____ STATE DEPARTMENT OF CORRECTIONS/JUVENILE JUSTICE
_____ STATE EMPLOYMENT SERVICE AGENCY
_____ VETERAN'S ADMINISTRATION
_____ WORKERS COMPENSATION
_____ OTHER STATE AGENCIES
_____ VR AGENCIES IN OTHER STATES

ACCOMMODATIONS FOR COMMUNICATIONS (CHECK ONE)

_____ REGULAR PRINT
_____ BRAILLE
_____ LARGE PRINT
_____ TAPE
_____ CD _____ 3,5 DISK
_____ OTHER LANGUAGE (SPECIFY)_____

FOR OFFICE USE ONLY

Information about employment

ARE YOU WORKING? _____ YES _____ NO

If yes, where: _____ Job title: _____ Hours per week: _____

If yes, current weekly earnings: _____ (gross wages, salaries, tips or commissions before payroll or tax deductions)

FOR OFFICE USE ONLY – EMPLOYMENT AT APPLICATION

_____ Employment without Supports in Integrated Setting
_____ Extended Employment
_____ Self-employment (except BEP)
_____ State Agency-managed Business Enterprise Program (BEP)
_____ Homemaker
_____ Unpaid Family Worker
_____ Employment with Supports in Integrated Setting
_____ Not employed: Student in Secondary Education
_____ Not employed: All other Students
_____ Not employed: Trainee, Intern or Volunteer
_____ Not employed: Other

IF YOU HAVE WORKED BEFORE, PLEASE LIST THE FOLLOWING INFORMATION FOR YOUR MOST RECENT JOBS:

NAME OF BUSINESS: _____

JOB YOU HAD: _____

TIME PERIOD WHEN YOU WORKED THERE: _____

REASON FOR LEAVING: _____

NAME OF BUSINESS: _____

JOB YOU HAD: _____

TIME PERIOD WHEN YOU WORKED THERE: _____

REASON FOR LEAVING: _____

NAME OF BUSINESS: _____

JOB YOU HAD: _____

TIME PERIOD WHEN YOU WORKED THERE: _____

REASON FOR LEAVING: _____

WHAT ARE THE STRENGTHS OR SKILLS YOU HAVE THAT ARE HELPFUL IN THE WORKPLACE?

Information about resources

ARE YOU CURRENTLY RECEIVING ANY OF THE FOLLOWING?

IF YES, PLEASE CHECK THEN LIST THE MONTHLY AMOUNT.

			FOR OFFICE USE ONLY
_____ SSDI (SOCIAL SECURITY DISABILITY INSURANCE)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ SSI (SUPPLEMENTAL SECURITY INCOME)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ GENERAL ASSISTANCE (PUBLIC ASSISTANCE)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ VETERANS' DISABILITY BENEFITS	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ WORKERS COMPENSATION	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ ANY OTHER PUBLIC SUPPORT	AMOUNT:	$ _____	VERIFIED? Y/N_____

WHAT IS YOUR PRIMARY (LARGEST) SOURCE OF SUPPORT? CHECK ONE.

_____ EMPLOYMENT EARNINGS
_____ PERSONAL INCOME (INTEREST, DIVIDENDS, RENT, RETIREMENT INCLUDING SOCIAL SECURITY RETIREMENT)
_____ FAMILY AND FRIENDS (INCLUDES EARNINGS OF A SPOUSE)
_____ GENERAL ASSISTANCE (PUBLIC ASSISTANCE)
_____ VETERANS' DISABILITY BENEFITS
_____ PUBLIC SUPPORT (SSI, SSDI, TANF)
_____ ALL OTHER SOURCES (INCLUDE PRIVATE DISABILITY INSURANCE AND PRIVATE CHARITIES)

TO HELP US COORDINATE YOUR SERVICES, PLEASE CHECK OTHER SERVICES YOU ARE RECEIVING.

YOU MAY CHECK UP TO THREE.

_____ AMERICAN INDIAN VR SERVICES PROGRAM
_____ CENTER FOR INDEPENDENT LIVING
_____ CHILD PROTECTIVE SERVICES
_____ A REHABILITATION PROGRAM IN YOUR COMMUNITY
_____ CONSUMER ORGANIZATION OR ADVOCACY GROUP
_____ GRADE SCHOOL OR HIGH SCHOOL
_____ UNIVERSITY, COLLEGE OR TECHNICAL SCHOOL
_____ EMPLOYER
_____ TICKET TO WORK EMPLOYMENT NETWORK
_____ FEDERAL STUDENT AID (PELL, SEOG, WORK STUDY)
_____ INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AGENCY
_____ DOCTOR OR HOSPITAL (PUBLIC OR PRIVATE)
_____ MENTAL HEALTH PROVIDER (PUBLIC OR PRIVATE)
_____ ONE-STOP EMPLOYMENT/TRAINING CENTER (KANSASWORKS)
_____ PUBLIC HOUSING AUTHORITY
_____ SOCIAL SECURITY ADMINISTRATION OR DISABILITY DETERMINATION SERVICES
_____ STATE DEPARTMENT OF CORRECTIONS/JUVENILE JUSTICE
_____ STATE EMPLOYMENT SERVICE AGENCY
_____ ECONOMIC AND EMPLOYMENT SERVICES
_____ VETERAN'S ADMINISTRATION
_____ WORKERS COMPENSATION
_____ OTHER STATE AGENCIES
_____ VR AGENCIES IN OTHER STATES
_____ OTHER
_____ NONE

DO YOU HAVE ANY OF THE FOLLOWING TYPES OF MEDICAL INSURANCE COVERAGE?

_____ MEDICAID (KANCARE)
_____ MEDICARE
_____ PUBLIC INSURANCE FROM OTHER SOURCES (WORKERS COMPENSATION OR HEALTHWAVE)
_____ PRIVATE INSURANCE THROUGH YOUR OWN EMPLOYER
_____ NOT YET ELIGIBLE FOR PRIVATE INSURANCE THROUGH EMPLOYER, BUT WILL BE AFTER A CERTAIN PERIOD OF EMPLOYMENT
_____ PRIVATE INSURANCE THROUGH OTHER MEANS (SUCH AS THROUGH PARENTS OR FAMILY)

Information about your expenses

HOW MANY PEOPLE CURRENTLY LIVE AT YOUR HOUSE? _____ **(INCLUDE RELATIVES AND OTHERS)**

WHAT ARE THE CURRENT MONTHLY EXPENSES FOR YOUR HOUSEHOLD? PLEASE LIST BELOW

HOUSING	AMOUNT:	$ _____	WATER	AMOUNT:	$ _____
NATURAL GAS	AMOUNT:	$ _____	CABLE	AMOUNT:	$ _____
ELECTRICITY	AMOUNT:	$ _____	INTERNET	AMOUNT:	$ _____
PROPANE	AMOUNT:	$ _____	TELEPHONE	AMOUNT:	$ _____
TRASH	AMOUNT:	$ _____	CELL PHONE	AMOUNT:	$ _____

IF YOU ARE FOUND ELIGIBLE, YOU MAY BE ASKED TO PROVIDE DOCUMENTATION OF THESE EXPENSES, DEPENDING ON SERVICES THAT WOULD BE INCLUDED IN YOUR IPE.

Acknowledgements

In making this application for vocational rehabilitation services, I acknowledge that:

- I am applying for vocational rehabilitation services for the specific purpose of getting and/or keeping a job.
- It is my responsibility to inform my counselor of any changes related to this application, such as changes in my address, income or employment.
- **Prior** written approval from my counselor is needed before Rehabilitation Services will pay for any services.
- Payment for some services may be based on financial need according to my personal or family income.
- I expressly give permission for information about me to be shared within the Department for Children and Families (DCF). Rehabilitation Services will also have access to information in my Social Security, Disability Determination, DCF, and employment records.
- No one will be discriminated against by Rehabilitation Services because of disability, race, religion, sex, color, national origin, length of residency in the state, or ancestry.
- I have received a Handbook of Services.

_____ _____
APPLICANT'S SIGNATURE DATE

_____ _____
PARENT'S, GUARDIAN'S OR LEGAL REPRESENTATIVE SIGNATURE DATE

_____ _____ _____ _____
PARENT, GUARDIAN, REPRESENTATIVE ADDRESS CITY STATE ZIP CODE

_____ _____ _____
PARENT, GUARDIAN, REPRESENTATIVE PHONE CELL PHONE EMAIL ADDRESS