



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 <i>YOU MUST HAVE A VISA WHICH ALLOWS EMPLOYMENT IN THE COMPETITIVE MARKETPLACE TO BE ELIGIBLE FOR SERVICES.</i>		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)? _____		

<p>HIGHEST LEVEL OF EDUCATION (CHECK ONE)</p> <p><input type="checkbox"/> NO FORMAL SCHOOLING</p> <p><input type="checkbox"/> ELEMENTARY (GRADES 1-8)</p> <p><input type="checkbox"/> SOME HIGH SCHOOL BUT NO DIPLOMA (GRADES 9-12)</p> <p><input type="checkbox"/> SPECIAL EDUCATION CERTIFICATE/DIPLOMA OR CERTIFICATE OF ATTENDANCE</p> <p><input type="checkbox"/> HIGH SCHOOL GRADUATE OR GED</p> <p><input type="checkbox"/> SOME UNIVERSITY, COLLEGE OR TECH COLLEGE BUT NO DEGREE OR CERTIFICATE</p> <p><input type="checkbox"/> ASSOCIATE DEGREE</p> <p><input type="checkbox"/> BACHELOR'S DEGREE</p> <p><input type="checkbox"/> MASTER'S DEGREE</p> <p><input type="checkbox"/> DEGREE ABOVE MASTER'S, SUCH AS PH.D., ED.D., J.D.</p> <p><input type="checkbox"/> VOCATIONAL/TECHNICAL CERTIFICATE</p> <p><input type="checkbox"/> OCCUPATIONAL CREDENTIAL BEYOND UNDERGRADUATE</p> <p><input type="checkbox"/> OCCUPATIONAL CREDENTIAL BEYOND GRADUATE</p>	<p>CURRENT LIVING ARRANGEMENT (CHECK ONE)</p> <p><input type="checkbox"/> PRIVATE RESIDENCE (ON YOUR OWN, WITH YOUR FAMILY OR WITH A ROOMMATE)</p> <p><input type="checkbox"/> GROUP HOME</p> <p><input type="checkbox"/> REHABILITATION FACILITY</p> <p><input type="checkbox"/> MENTAL HEALTH FACILITY</p> <p><input type="checkbox"/> NURSING HOME</p> <p><input type="checkbox"/> JAIL OR CORRECTIONAL FACILITY</p> <p><input type="checkbox"/> HALFWAY HOUSE</p> <p><input type="checkbox"/> SUBSTANCE ABUSE TREATMENT CENTER</p> <p><input type="checkbox"/> HOMELESS/SHELTER</p> <p><input type="checkbox"/> OTHER</p>
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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)

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

<p>ACCOMMODATIONS FOR COMMUNICATIONS (CHECK ONE)</p> <p><input type="checkbox"/> REGULAR PRINT</p> <p><input type="checkbox"/> BRAILLE</p> <p><input type="checkbox"/> LARGE PRINT</p> <p><input type="checkbox"/> TAPE</p> <p><input type="checkbox"/> CD <input type="checkbox"/> 3,5 DISK</p> <p><input type="checkbox"/> OTHER LANGUAGE (SPECIFY) _____</p>	<p>FOR OFFICE USE ONLY</p>
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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

_____ Employment with Supports in Integrated Setting

_____ Extended Employment

_____ Not employed: Student in Secondary Education

_____ Self-employment (except BEP)

_____ Not employed: All other Students

_____ State Agency-managed Business Enterprise Program (BEP)

_____ Not employed: Trainee, Intern or Volunteer

_____ Homemaker

_____ Not employed: Other

_____ Unpaid Family Worker

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
<input type="checkbox"/> SSDI (SOCIAL SECURITY DISABILITY INSURANCE)	AMOUNT: \$ _____		VERIFIED? Y/N _____
<input type="checkbox"/> SSI (SUPPLEMENTAL SECURITY INCOME)	AMOUNT: \$ _____		VERIFIED? Y/N _____
<input type="checkbox"/> TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES)	AMOUNT: \$ _____		VERIFIED? Y/N _____
<input type="checkbox"/> GENERAL ASSISTANCE (PUBLIC ASSISTANCE)	AMOUNT: \$ _____		VERIFIED? Y/N _____
<input type="checkbox"/> VETERANS' DISABILITY BENEFITS	AMOUNT: \$ _____		VERIFIED? Y/N _____
<input type="checkbox"/> WORKERS COMPENSATION	AMOUNT: \$ _____		VERIFIED? Y/N _____
<input type="checkbox"/> 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.

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

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