

PID:

CID:

The Pennsylvania Office of Vocational Rehabilitation (OVR) helps individuals with disabilities prepare for, obtain, or keep suitable employment.

TO BE ELIGIBLE FOR OVR SERVICES YOU MUST:

1. Have a disability that causes a substantial impediment to employment
2. Need services from OVR to achieve employment, and
3. Be able to benefit from services in terms of an employment outcome.

CONFIDENTIALITY

All medical and personal information shall be held as confidential. Use of such information will be limited to purposes directly connected with your rehabilitation program.

*** Indicates Required Field - Please complete each question to the best of your knowledge and ability.**

PERSONAL INFORMATION

APPLICATION DATE	* FIRST NAME	MI	* LAST NAME	SUFFIX	MAIDEN OR OTHER NAME
* LOCATION ADDRESS		* CITY		* STATE	* ZIP CODE
* MAILING ADDRESS <input type="checkbox"/> SAME AS ABOVE		* CITY		* STATE	* ZIP CODE
* CORRESPONDENCE PREFERENCE <input type="checkbox"/> Email <input type="checkbox"/> Mail		* GENERAL CONTACT PREFERENCE <input type="checkbox"/> Location Address <input type="checkbox"/> Primary Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Mailing Address <input type="checkbox"/> Work Phone <input type="checkbox"/> Fax Number <input type="checkbox"/> Video Phone			
EMAIL ADDRESS		PRIMARY PHONE <input type="checkbox"/> TDD/TTY	WORK PHONE <input type="checkbox"/> TDD/TTY	CELL PHONE	VIDEO PHONE
FAX NUMBER	LANGUAGE PREFERENCE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		ADDITIONAL COMMUNICATION NEEDS <input type="checkbox"/> Foreign Language Interpreter <input type="checkbox"/> Braille <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Large Print <input type="checkbox"/> Other: _____		
CONTACT PERSON FIRST NAME		CONTACT PERSON LAST NAME		RELATIONSHIP TO CONTACT PERSON	CONTACT PERSON PHONE
SSN	* GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	* DATE OF BIRTH	* CITIZENSHIP STATUS <input type="checkbox"/> US Citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Non-US Citizen <input type="checkbox"/> Permanent Alien <input type="checkbox"/> Illegal Alien <input type="checkbox"/> Unknown <input type="checkbox"/> Temporary Alien		
CAN YOU LEGALLY WORK IN THE U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	* ETHNICITY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Latino <input type="checkbox"/> Do not wish to disclose		* RACE <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Do not wish to disclose		
* WHO REFERRED YOU TO OVR?					

CUSTOMER:

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OTHER PERSONAL INFORMATION (CONTINUED)

* ARE YOU A VETERAN?

Yes No

* IF A VETERAN, IS YOUR DISABILITY SERVICE CONNECTED? Yes No

* IF YES, PERCENTAGE OF DISABILITY _____ %

IF A VETERAN, ARE YOU ELIGIBLE FOR VA VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICES? Yes No

* VOTER REGISTRATION – OVR can help you register to vote. You are not required to register. Please select one of the following:

- I would like OVR to provide me with a Voter Registration Application, which I will complete and submit myself
- I would like OVR to help me complete and submit a Voter Registration Application
- I am already registered to vote
- I am not registered to vote and do not wish to register
- I am not registered to vote because I am under the age of 18
- I am not registered to vote because I am not eligible

EDUCATION INFORMATION

* ARE YOU A STUDENT?

Yes No

* IF A STUDENT, SELECT ONE OF THE FOLLOWING THAT APPLIES TO YOU

- I am a student in high school with a 504 accommodation plan
- I am a student in high school with an Individualized Education Plan (IEP)
- I am a student in high school who does not have a 504 accommodation plan or an IEP
- I am a student in postsecondary education

* IF A STUDENT, LIST YOUR ANTICIPATED GRADUATION DATE OR ANTICIPATED DATE OF COMPLETION

DISABILITY AND EMPLOYMENT INFORMATION

Please complete to the best of your ability. If you are unsure how to answer a question, you will have the opportunity to review your answers with an OVR counselor during your initial meeting. Please bring any medical information or records you have to your initial interview. Having this information up front can reduce the length of time it takes to determine your eligibility for OVR services.

* WHAT IS YOUR DISABILITY (OR DISABILITIES)?

* YEAR OF ONSET

* ARE YOU CURRENTLY EMPLOYED?

Yes No

* HOW CAN OVR HELP YOU TO GET, KEEP, OR ADVANCE IN A JOB?

* WHAT JOBS OR CAREERS INTEREST YOU? COMPLETE TO THE BEST OF YOUR ABILITY. YOU MAY WRITE "UNKNOWN" IF YOU DO NOT HAVE A CAREER INTEREST AT THIS TIME.

HOUSEHOLD INFORMATION

* SELECT THE OPTION WHICH BEST DESCRIBES YOUR CURRENT LIVING ARRANGEMENT OR PLACE OF RESIDENCE, WHETHER PERMANENT OR TEMPORARY

- | | |
|--|---|
| <input type="checkbox"/> Private Residence (independent or with family/other person) | <input type="checkbox"/> Adult Correctional Facility |
| <input type="checkbox"/> Community Residential/Group Home | <input type="checkbox"/> Halfway House |
| <input type="checkbox"/> Rehabilitation Facility | <input type="checkbox"/> Substance Abuse Treatment Center |
| <input type="checkbox"/> Mental Health Facility | <input type="checkbox"/> Homeless/Shelter |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other |

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HOUSEHOLD INFORMATION (CONTINUED)

*** WHAT IS YOUR CURRENT MODE(S) OF TRANSPORTATION? (Select all that apply)**

- Personal vehicle (with driver's license)
- Personal vehicle (no driver's license)
- Public transportation
- Friends and/or relatives
- Shared ride service
- Paratransit
- None, I currently cannot get around my community
- Other (Please explain) _____

*** WHAT IS YOUR PRIMARY SOURCE OF SUPPORT?**

- Personal Income (employment earnings, interest, dividends, rent, retirement including social security)
 - Family and Friends
 - Public Support (SSI, SSDI, TANF, etc.)
 - All other sources (e.g., private disability insurance and private charities)
- * For all other sources, please specify: _____

*** IF YOU ARE RECEIVING PUBLIC SUPPORT, SELECT EACH TYPE YOU ARE RECEIVING. (Select all that apply)**

- Supplemental Security Income (SSI)
- Social Security Disability Insurance (SSDI)
- Temporary Assistance for Needy Families (TANF)
- Veteran's Disability Benefits
- Worker's Compensation
- *Other Public Support
- Unemployment Insurance

**Other public support may include any cash payments you receive beyond those listed. Please include payments made by Federal, State and Local Governments for retirement or survivor benefits, as well as any temporary public support payments you are currently receiving outside of those already listed.*

WAIVER SERVICES AND OTHER AGENCY INVOLVEMENT

*** ARE YOU CURRENTLY RECEIVING MEDICAL ASSISTANCE (MA) WAIVER SERVICES FROM THE PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES?**

- Yes
- No – *If no, skip to Other Agencies section below*

*** MA WAIVER SERVICE AGENCY AND TYPE**

- | | |
|---|--|
| <ul style="list-style-type: none"> 1. Office of Developmental Programs – Intellectual Disabilities <ul style="list-style-type: none"> <input type="checkbox"/> Consolidated <input type="checkbox"/> Personal/Family Directed Services (P/FDS) 2. Office of Developmental Programs – Autism <ul style="list-style-type: none"> <input type="checkbox"/> Adult Autism <input type="checkbox"/> Adult Community Autism Program (ACAP) | <ul style="list-style-type: none"> 3. Office of Long Term Living <ul style="list-style-type: none"> <input type="checkbox"/> COMMCARE (TBI) <input type="checkbox"/> OBRA (Dev Disabilities not ID/Autism) <input type="checkbox"/> Independence (Physical Disabilities) <input type="checkbox"/> Attendant Care |
|---|--|

SUPPORT COORDINATOR/MA CASE MANAGER

SUPPORT COORDINATOR/MA CASE MANAGER PHONE

SUPPORT COORDINATOR/MA CASE MANAGER EMAIL

OTHER AGENCIES - List any other agencies, facilities, rehabilitation programs, or law enforcement agencies from which you are currently receiving or previously received services.

* AGENCY OR PROGRAM NAME	SERVICES RECEIVED	POINT OF CONTACT	CONTACT PHONE &/OR EMAIL

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MEDICAL INFORMATION

*** PLEASE SELECT EACH TYPE OF INSURANCE THAT YOU CURRENTLY HAVE**

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private insurance through employer |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Not yet eligible for private insurance through employer |
| <input type="checkbox"/> Medical Assistance for Workers with Disabilities (MAWD) | <input type="checkbox"/> Private insurance through other means |
| <input type="checkbox"/> Public Insurance from Other Sources | <input type="checkbox"/> I currently do not have medical insurance |
| <input type="checkbox"/> State or Federal Affordable Care Act Exchange | |

*** ARE YOU AN INDIVIDUAL WITH BLINDNESS OR A VISUAL IMPAIRMENT?**

- Yes No *(If NO, skip to Medical Conditions below)*

IF YES, WHAT IS YOUR VISUAL ACUITY (WITH BEST CORRECTION)

- | | |
|---|--|
| <input type="checkbox"/> 20/20 – 20/69 | <input type="checkbox"/> 20/200 or greater |
| <input type="checkbox"/> 20/70 – 20/199 | |

VISUAL FIELDS

- | | |
|--|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Restricted 20 degrees or less |
| <input type="checkbox"/> Somewhat Restricted | <input type="checkbox"/> Unknown |

HOW IS YOUR EYE CONDITION TREATED?

HAVE YOU HAD VISION SERVICES BEFORE?

- Yes No

IF YOU HAD VISION SERVICES BEFORE, WHAT KIND AND WHERE?

MEDICAL CONDITIONS - PLEASE SELECT ALL CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST, AS WELL AS THOSE YOU ARE CURRENTLY EXPERIENCING

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol addiction | <input type="checkbox"/> Deafness | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Amputations | <input type="checkbox"/> Deaf-blindness | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease or other neurological disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Asthma or allergies | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Respiratory disorder |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> End stage renal failure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Specific learning disability |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hard of hearing | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Cardiac (heart) problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Immune deficiencies | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Congenital condition | <input type="checkbox"/> Injury resulting in change or loss of limb function | <input type="checkbox"/> Vision impairment |
| <input type="checkbox"/> Cognitive disability | <input type="checkbox"/> Intellectual disability | |
| <input type="checkbox"/> Cystic fibrosis | | |

Please select any areas that make it difficult for you to get, keep, or advance in a job as a result of your disability/disabilities. At least one item in this section must be marked.

MOBILITY (Moving efficiently from place to place)

- | | | |
|--|--|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Requires a wheelchair |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Requires a brace, cane, or other device | |
| <input type="checkbox"/> Using public transportation | | |

SELF CARE (Skills needed to fulfill basic needs related to health, safety, hygiene and financial management)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Living on your own (without supervision) | <input type="checkbox"/> Taking medication on your own | <input type="checkbox"/> Grooming |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Money management | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Eating | <input type="checkbox"/> Housekeeping |

WORK TOLERANCE (Carrying out physical and/or cognitive work tasks in an efficient and effective manner over a sustained period of time)

- | | | |
|--|--|---|
| <input type="checkbox"/> Weakness/pain in arms/hands | <input type="checkbox"/> Strength | <input type="checkbox"/> Temperature changes |
| <input type="checkbox"/> Stamina | <input type="checkbox"/> Sitting, standing, bending | <input type="checkbox"/> Chemicals |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Working a full shift | <input type="checkbox"/> Light/visual stimuli |
| <input type="checkbox"/> Weakness/pain in legs/feet | <input type="checkbox"/> Balance | <input type="checkbox"/> Fumes/dust |
| <input type="checkbox"/> Noises/vibrations | <input type="checkbox"/> Concentrating for several hours | <input type="checkbox"/> Numbness |

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MEDICAL INFORMATION (CONTINUED)

INTERPERSONAL SKILLS (Effectively interacting with others)

- | | | |
|--|--|---|
| <input type="checkbox"/> Getting along with others | <input type="checkbox"/> Controlling emotions | <input type="checkbox"/> Participating in activities due to feeling withdrawn, anxious, or isolated |
| <input type="checkbox"/> Accepting supervision | <input type="checkbox"/> Understanding social cues | |
| <input type="checkbox"/> Cooperation | <input type="checkbox"/> Maintaining eye contact | |

WORK SKILLS (Critical skills needed to carry out essential work functions such as functional academics, motor skills, processing speed, memory, and communication)

- | | | |
|---|---|--|
| <input type="checkbox"/> Identifying/Counting Money | <input type="checkbox"/> Reading Instructions | <input type="checkbox"/> Hand/Eye Coordination |
| <input type="checkbox"/> Learning New Tasks | <input type="checkbox"/> Motor Coordination | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Memory | <input type="checkbox"/> Speed | <input type="checkbox"/> Attention |

COMMUNICATION (Accurately and efficiently transmitting or receiving information verbally or non-verbally)

- | | | |
|--|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Requires Assistive Device(s) to Communicate | <input type="checkbox"/> Writing | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Interviewing | <input type="checkbox"/> Hearing |

SELF-DIRECTION (Planning, initiating, and monitoring behavior with respect to a desired outcome that serves to benefit the individual)

- | | | |
|---|--|--|
| <input type="checkbox"/> Learning Consequences to Actions | <input type="checkbox"/> Require Assistive Device for Planning, Organizing, Etc. | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Making Decisions on Your Own | <input type="checkbox"/> Being On Time | <input type="checkbox"/> Adjusting to New Conditions |
| <input type="checkbox"/> Being Organized | | <input type="checkbox"/> Planning Activities |

PLEASE ENTER COMMENTS TO BETTER EXPLAIN THE ABOVE INFORMATION OR TO ADD ADDITIONAL INFORMATION

MEDICAL PROFESSIONAL(S) TREATING YOUR DISABILITY (DISABILITIES)

MEDICAL SPECIALIST #1

SPECIALIST NAME	ADDRESS	CITY	STATE	ZIP CODE
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DATE OF LAST APPOINTMENT	TYPE OF MEDICAL PROFESSIONAL			
	<input type="checkbox"/> Family Doctor	<input type="checkbox"/> Therapist	<input type="checkbox"/> Treatment Facility	
	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Health Care Provider	<input type="checkbox"/> Optometrist/Ophthalmologist	
	<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital		

SPECIALIST NAME	ADDRESS	CITY	STATE	ZIP CODE
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	<input type="checkbox"/> Family Doctor	<input type="checkbox"/> Therapist	<input type="checkbox"/> Treatment Facility	
	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Health Care Provider	<input type="checkbox"/> Optometrist/Ophthalmologist	
	<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital		

SPECIALIST NAME	ADDRESS	CITY	STATE	ZIP CODE
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DATE OF LAST APPOINTMENT	TYPE OF MEDICAL PROFESSIONAL			
	<input type="checkbox"/> Family Doctor	<input type="checkbox"/> Therapist	<input type="checkbox"/> Treatment Facility	
	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Health Care Provider	<input type="checkbox"/> Optometrist/Ophthalmologist	
	<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital		

MEDICATIONS

NAME	REASON	SIDE EFFECTS (IF APPLICABLE)