Please return the completed form to:

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)

Application for VR Services

VR-04 (7/14)

Please print or type all entries

NAME *Last* *First* *Middle Initial*

GENDER ☐ Male ☐ Female

If you have been known by **another name**, enter here: *Last* *First* *Middle Initial*

HOME ADDRESS *Street* *Apartment Number*

City *State* *Zip + 4 Code* *County*

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

If your **MAILING ADDRESS** is different than your home address, please complete the mailing address information below.

MAILING ADDRESS *Street* *Apartment Number*

City *State* *Zip + 4 Code* *County*

PHONE NUMBER(S) *where we can reach you or leave a message:*

Area code 1. ( ) - *Home* ☐ *Cell* ☐ *Other* ☐

Area code 2. ( ) *Home* ☐ *Cell* ☐ *Other* ☐

*Email:*______________________________

Best time to call
1.
2.

DATE OF BIRTH
Month Day Year
☐☐-☐☐-☐☐

Race/Ethnicity-Choose ALL that apply. If left blank ACCES will complete. If Hispanic or Latino is checked, please check additional box.

☐ American Indian or Alaska Native
☐ Asian (includes Indian Subcontinent)
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White

What is your disability?

Who referred you to us?

MARITAL STATUS: (*Circle Response*)

(1) Married; (2) Widowed; (3) Divorced

(4) Separated (5) Never Married

I hereby apply for rehabilitation services: *Signature of applicant, parent, or legal guardian.*

*Date*________________

X *(Sign here.)*

• • • *Please answer the questions below and on the back of this form.* • • •

You do not have to answer these questions now, but your answers will help ACCES-VR process your application.

Have you ever received services from ACCES-VR or its former name, the Office of Vocational and Educational Services for Individuals with Disabilities (VESID)?.. ☐ Yes ☐ No

Are you now receiving services from *one* or *more* agencies?.. ☐ Yes ☐ No

If you answered yes, indicate agency name(s), address(es) and contact person(s):

(1)

(2)

Describe how your disability limits your ability to work.

What services are you seeking from ACCES-VR?

Are you disabled because of a work-related injury? ☐ Yes ☐ No

Do you use any assistive devices or aids? ☐ Yes ☐ No

Do you have a NYS driver's license? ☐ Yes ☐ No

Do you have a driver's license from a state other than New York? ☐ Yes ☐ No

Do you have access to a motor vehicle? ☐ Yes ☐ No

Do you use public transportation? ☐ Yes ☐ No

Are you able to leave your home? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Are you a citizen of the United States? ☐ Yes ☐ No

If no, are you legally permitted to work in this country? ☐ Yes ☐ No

Check the benefits you now receive?

☐ SSI ☐ SSDI ☐ Workers Compensation

☐ Other, specify_______________

Do you regularly see a doctor or clinic about your disability? ☐ Yes ☐ No, If yes, indicate date of last visit: ___________
Please provide the name and address of doctor(s) and clinic(s):
(1) (2)

Circle the highest grade you have successfully completed, and check the applicable box(es)
1 2 3 4 5 6 8 9 10 11 12 GED or High School Equivalency Diploma ☐ Yes ☐ No 13 14 15 16 College 17 Graduate School 20 Doctorate

Special Education ☐ Yes ☐ No Do you now attend high school? ☐ Yes ☐ No Indicate college degree(s) earned: ____________________

Name and address of school you last attended: *Name of School* *Address*

List below other people in your household

Full Name	Age	Their Relationship to You

List below the people ACCES-VR can contact if we are unable to reach you using the information on page 1.

Name	Address	Phone

List below your work history (include attachments for additional jobs, if necessary)

Employer Name and Address	Dates Employed From - To	Weekly Earnings	Job Title and Duties, and Reason for Leaving

Persons applying for or receiving rehabilitation services have the right to have any actions or decisions of this Office reviewed. A description of the review process and form can be obtained from any ACCES-VR District Office.

All information will be kept confidential and is subject to verification.

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Confidential Health Assessment

VR-26 (1/11)

This form gathers information on your general health. The information is important and will help us in the eligibility and vocational planning process. This information is confidential and will not be shared outside of ACCES-VR without your permission.

NAME: *Last* *First* MI	DATE
MAILING ADDRESS: *Street* *Apartment and/or Building Number*	
City State Zip Code	DATE OF BIRTH
Would you describe your health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
When was your last general physical examination? ____________ *date*	
Your doctor or clinic's name, address, and telephone number	

Please check the box(es) that best describes you

Do you have any difficulty with:	No Difficulty	Some Difficulty	Cannot Do
Walking	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Using your right foot / leg	☐	☐	☐
Using your left foot / leg	☐	☐	☐
Using your right hand / arm	☐	☐	☐
Using your left hand / arm	☐	☐	☐
Reaching above your shoulders	☐	☐	☐
Moving your fingers	☐	☐	☐
Hearing	☐	☐	☐
Seeing	☐	☐	☐
Speaking	☐	☐	☐
Pushing	☐	☐	☐
Pulling	☐	☐	☐
Carrying	☐	☐	☐
Lifting	☐	☐	☐
Reading	☐	☐	☐
Doing arithmetic	☐	☐	☐
Working with people	☐	☐	☐

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Do you now have or have you had:	Yes	*No*		Yes	No
Mental Retardation	☐	☐	Speech Problems	☐	☐
Vision Problems	☐	☐	Head Injury	☐	☐
Hearing Problems	☐	☐	Cerebral Palsy	☐	☐
Orthopedic Limitations	☐	☐	Multiple Sclerosis	☐	☐
Mental / Emotional Conditions	☐	☐	Muscular Dystrophy	☐	☐
Substance Use Disorders	☐	☐	Diabetes	☐	☐
Allergies / Asthma	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Arthritis	☐	☐
Respiratory I Lung Disorder	☐	☐	Skin Disease/ Rashes	☐	☐
Ulcers, Colitis	☐	☐	Cancer	☐	☐
Kidney Disease	☐	☐	Learning Disability	☐	☐
High Blood Pressure	☐	☐	HIV Related Diseases	☐	☐
Seizure Disorder/ Epilepsy	☐	☐	Other.	☐	☐
	☐	☐	____________	☐	☐

if you answered "Yes to any of the above, please describe how it might affect vocational training or your ability to work. ....

....

....

Do you have difficulty working Where there is / are:	No Difficulty	Some Difficulty	Cannot Do		No Difficulty	Some Difficulty	Cannot do
Temperature / humidity changes	☐	☐	☐	Dust / fumes	☐	☐	☐
Unprotected heights	☐	☐	☐	Loud noises	☐	☐	☐
Moving machinery	☐	☐	☐	High stress	☐	☐	☐
Other situations: ____________					☐	☐	☐

Can you work full time? ☐ Yes ☐ No If you answered **"No"**, how many hours a day do you feel you can work? __________ hours

Do you need special parking? ☐ Yes ☐ No

What special accommodations do you need? ☐ wheelchair ☐ hearing aid ☐ cane / walker ☐ TTY ☐ attendant ☐ interpreter ☐ others ____________ ____________

____________ ____________

Do you have any other physical or mental condition which might affect vocational training or your ability to work? If so, please explain. ____________

....

....

Are you currently taking any medication? if so, please explain. ....

....

I certify, by my signature below, that this information is complete and true to the best of my knowledge.

____________________ ____________________

Signature Completed by

Please feel free to attach additional explanation(s)

7-055638

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)

Authorization to Release / Obtain Information

(Please read instructions on page two before completing this form.) **VR-22 (08/11)**

CONSUMER NAME	**CONSUMER ID NUMBER**
CONSUMER ADDRESS ***[include street (apartment number or building, if applicable), city, state, zip]***	

The Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR) has my permission to release or obtain information indicated in item #1 below. This information may include reports about my physical or mental condition, school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services. I understand that this information will be treated as confidential and privileged and will only be used for the purpose of obtaining services offered through ACCES-VR.

I understand that information disclosed according to this consent may be subject to re-disclosure and will no longer be subject to the HIPPA privacy requirements. I can change my mind about this release, by telling ACCES-VR in writing that I do not want any further information to be given out. This will not affect actions already taken with my permission.

My permission to release or obtain information expires on date ___________ or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released or obtained? *(Be specific.)*

2. Who is releasing this information? *(Insert the full name of this person or organization.)*

3. Who is receiving this information? *(Insert complete information about this person.)*

Name:
Title:
Address:

4. Why is this information needed?

I have read all of the information on this form. I understand and agree to what it says.

Consumer or Parent/Guardian Signature: ______________________________ *Date:* _______________

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records. Form VR-540, *Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Alcoholism or Substance Abuse,* must be attached to this form when necessary.

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Authorization to Release / Obtain Information

Instructions

This *Authorization to Release / Obtain Information* form is to be used when information is to be released by or is to be requested by ACCES-VR. All such information will be treated as confidential and privileged and used only for the purposes of ACCES-VR services. Information ACCES-VR may have in the records, but obtained via a release from another provider, may be restricted from further dissemination.

If at any time the consumer wishes to terminate this release, he/she may do so by writing to ACCES-VR. Withdrawal of permission to release/obtain confidential information will not retroactively cover any information that has already been released or obtained.

You must:

- be as specific and precise as possible;
- not leave any questions unanswered;
- include a specific date on which the permission will end;
- include names of persons and titles or organization name receiving or sending information; and
- mark the VR-22 as void if the consumer rescinds his/her permission in writing to release/obtain further information.

Box #1: State the exact information that will be released/obtained (e.g., Medical Evaluation by Dr. Diaz dated 1/16/94; Educational Summary dated 10/5/95 from John Jay High School).

Box #2: State the name and title (if known) of the person releasing the information (e.g., Ms. Jean Jones, Vocational Rehabilitation Counselor; Dr. Browne, School Psychologist).

Box #3: Complete the name, title, and address of the person receiving the information. If an ACCES-VR counselor is sending the same document to several sources (e.g., a general medical report to a medical specialist and to an intake worker at a facility), multiple names, addresses, and titles can be filled in this box. It is not sufficient to indicate the report will be sent to a facility or program. ***A specific individual must be indicated***, so that individual becomes responsible for the confidential information.

Box #4: Provide a brief summary that indicates why the information is needed.

The consumer or parent/guardian must sign and date the form at the bottom. This date sets the timeframe for which information may be exchanged under this release form. If a different expiration date is to be established this must be indicated on the form.

ACCES-VR High School Applicant Supplemental Data

Name: **Date of Birth:**

Referral Information ***to be completed by person making referral***

Referral must include one of the following:	Current IEP and psychological report ☐	Current 504 Plan and supporting documents ☐	Current Physician Report with diagnosis ☐

CSE Classification, 504 or Medical Diagnosis: ______________________

Grade Most Recently Completed: ____________ Expected Year of School Completion: ____________

Type of Degree/Certificate Anticipated: ☐ Regents ☐ Local ☐ CDOS ☐ Skills & Achievement

Name of person making referral: ______________________ Title: ____________

Email Contact: ______________________ Phone Number: ____________

School District Student Resides In: ______________________

Complete Section Below: OPTIONAL

Can Choose To Complete With ACCES-VR Counselor At First Meeting

Health, Residence & Work Questionnaire: To Be Completed By Student And Parent/Guardian

Do you have or have you ever had any of the following conditions?

☐ Intellectual Disability	☐ Speech Problems	☐ Ulcers/Colitis	☐ Vision Problems
☐ Head Injury	☐ Kidney Disease	☐ Hearing Problems	☐ Cerebral Palsy
☐ High Blood Pressure	☐ Orthopedic Limitations	☐ Multiple Sclerosis	☐ Seizure Disorder
☐ Mental Illness	☐ Muscular Dystrophy	☐ Cancer	☐ Drug/Alcohol Abuse
☐ Diabetes	☐ Learning Disability	☐ Allergies/Asthma	☐ Stroke
☐ HIV Related Disease	☐ Heart Disease	☐ Arthritis	☐ Skin Disease/Rash
☐ Respiratory/Lung Disorder	☐ Other: ____________		

If you checked any of the above, please describe how it might affect vocational training or your ability to work:

____

____

Living Arrangements at Application:

☐ Private Residence ☐ Community Residence ☐ Mental Health Facility ☐ Correctional Facility

☐ Halfway House ☐ Homeless ☐ Substance Abuse Treatment Facility ☐ Other

Work Status at Application:

☐ Employed with a job coach ☐ Employed on my own ☐ Not presently employed

Medical Insurance at Application:

☐ Medicaid ☐ Medicare ☐ Other Private ☐ Private Through Employment ☐ Workers Compensation ☐ None

Can you work full time upon school completion? ☐ Yes ☐ No

If you answered "No", how many hours a day do you feel you can work? ____________

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)

Information Release Authorization VR-21 (3/12)

Name: ____
Print full name

Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR) has my permission to release or obtain information from agencies [including the Client Assistance program (CAP)], individuals, or employers as are concerned with my vocational rehabilitation. This information may include reports about my physical or mental condition, official school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services.

I understand that:

- All such information will be treated as confidential and privileged;
- The information will be used only for the purpose of obtaining services offered through ACCES-VR;
- I can withdraw my permission to release or obtain information by writing to ACCES-VR (this will not affect actions already taken with my permission); and
- ACCES-VR may need to use the information to administer the vocational rehabilitation program

______________________________ ______________
Signature ***Date***

______________________________ ______________
Parent/Guardian Signature (If Under 18 Years of Age) ***Date***

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8-064609