

Thank you for your interest in OVR services! Please see the information below for a link to our OVR Services Brochure and steps to move forward if you are interested in services or application.

**General OVR BROCHURE-** (Cursor+ Ctrl+ left click): [Rehabilitation Services Handbook \(pa.gov\)](http://www.dli.pa.gov/Individuals/Disability-Services/ovr/Pages/Rehabilitation-Services-Handbook.aspx)

OR web address: [www.dli.pa.gov/Individuals/Disability-Services/ovr/Pages/Rehabilitation-Services-Handbook.aspx](http://www.dli.pa.gov/Individuals/Disability-Services/ovr/Pages/Rehabilitation-Services-Handbook.aspx)

**TO BEGIN THE PROCESS FOR OPEN CASE OVR SERVICES for 11<sup>th</sup> and 12<sup>th</sup> graders (which includes INDIVIDUAL Pre-Employment Transition Services:** Return all enclosed forms (LISTED BELOW) with the following:

- 1) ID (legal, driver's license, passport, drivers permit, school ID)  
\*\*Social security card copy OR birth certificate copy may be substituted for ID along with STUDENTS MOST RECENT IEP AND RE-EVALUATION
- 2.) SOCIAL SECURITY NUMBER (IF CARD COPY IS NOT PROVIDED AS PART OF ID REQUIREMENTS
- 3.) Students most recent IEP and Re-Evaluation

**OVR FORMS ENCLOSED WHICH NEED TO BE SIGNED AND RETURNED PRIOR TO APPLICATION BEING ENTERED**

**OVR-11 RIGHTS AND RESPONSIBILITIES**

**OVR 244 PRE-ETS RELEASE**

**OVR 134 SCHOOL RECORDS CONSENT**

**OVR 163 FOR SCHOOL DISTRICT INFORMATION**

**OVR 105 FINANCIAL NEEDS TEST**

**OVR 194 INITIAL INDIVIDUALIZED PLAN OF EMPLOYMENT (GENERAL SERVICES)**

Once these items are GATHERED and all forms have required signatures (student and parent) **PLEASE PLACE THEM ALL IN THIS BLUE FOLDER AND RETURN THIS FOLDER TO:** \_\_\_\_\_

you will then be contacted by your OVR counselor shortly by email, phone or through USPS mail to schedule the OVR APPLICATION APPOINTMENT and open OVR case services.

**OVR CASE SERVICES APPLICATION Timelines:**

**Application to Eligibility Determination = up to 60+ days.**

**Eligibility to Permanent Plan (Individualized Plan of Employment or IPE) = up to 90+ days (during this time your counselor will regularly meet with you for Vocational Guidance until you select a tentative job goal). \*Once your student is in PLAN (IPE) status, vocational guidance continues to work on: Self Advocacy Skills, Work Skills Training and Experiences such as Job Shadowing, Paid Work Experiences (PWE) and other programs, as well as continued job exploration counseling, college and post-secondary counseling, driver's evaluations and training, assistive technology evaluations and tech equipment, accommodations for work/college, specialized summer camps and programs and work readiness activities in preparation for job search and employment.**

**Kimberly A. Ragan, VRC, M.S., C.R.C.**

**PA Office of Vocational Rehabilitation- Washington District**

**724-531-1352 ©, Email [Kragan@pa.gov](mailto:Kragan@pa.gov)**

**PRE-EMPLOYMENT TRANSITION  
SERVICES RELEASE**

<b>STUDENT INFORMATION</b>			
<b>*FIRST NAME</b>	<b>MI</b>	<b>*LAST NAME</b>	<b>*DATE OF BIRTH</b>
<b>*MAILING ADDRESS</b>		<b>SOCIAL SECURITY NUMBER</b>	<b>PID</b>
<b>*EDUCATIONAL DISABILITY PROGRAMMING</b> (select one) <input type="checkbox"/> IEP <input type="checkbox"/> 504 Plan <input type="checkbox"/> None (Self-Disclosure of Disability)		<b>*BJJS/PACTT Student</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>*RACE</b> (select one) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Do not wish to disclose			
<b>*ETHNICITY</b> (select one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Do not wish to disclose		<b>GENDER</b> (select one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Do not wish to disclose	<b>*ANTICIPATED SCHOOL EXIT DATE</b>
		<b>SCHOOL/COLLEGE</b>	
<b>*GRADE</b>	<b>*COUNTY OF RESIDENCE</b>	<b>*SCHOOL DISTRICT OF RESIDENCE</b>	<b>PHONE NUMBER</b>
<b>PARENT NAME(S)</b>		<b>E-MAIL ADDRESS</b>	<input type="checkbox"/> Parent <input type="checkbox"/> Contact during daytime hours? <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

<b>RELEASE INFORMATION</b>
<p>The Office of Vocational Rehabilitation's (OVR) Pre-Employment Transition Services (Pre-ETS) help students with disabilities learn about themselves, understand work requirements, practice work skills, explore training options, and choose a career that may be further explored through individualized Vocational Rehabilitation Services.</p> <p>This release will remain valid until I exit from the school named above. I acknowledge that in completing this release for Pre-ETS, OVR may obtain or release confidential personal information (Full Name, Date of Birth, Ethnicity, Race, County of Residence, Contact Information, School District of Residence, Current Grade Level, Anticipated Exit Date, Pre-ETS Progress Reports, and Educational Programming Status) about me as follows:</p> <ul style="list-style-type: none"> <li>to purchase services or provide services for me from the following Pre-ETS providers (please include provider name and address):</li> </ul>

Blueprints: 150 W. Beau St., Washington, PA 15301; DiCenzo Personnel Specialists: 8110 Ohio River Blvd., Pittsburgh, PA 15202; Family Ties: 201 Carmichaels Plaza, Carmichaels, PA 15320; LifesWork of Western PA: 19 Eastgate Ave., Monessen, PA 15062; Transitional Employment Services (TEC): 330 Central Ave., Washington, PA 15301; Transitional Pathways to Independent Living: 42 E. Maiden St., Washington, PA 15301; ARC Human Services: 111 W. Pike St., P.O. Box 521, Canonsburg, PA 15317; The ARC Fayette Co: 80 Old New Salem Rd., Uniontown, PA 15401; Greene ARC, Inc: 197 Dunn Station Rd., Prosperity, PA 15329; Blind & Vision Rehab Services of Pittsburgh: 1816 Locust St., Pittsburgh, PA 15219;

- to collaborate with OVR providers and partners on my behalf;
- to report my progress to the school listed above;
- when required to disclose it pursuant to law or regulations;
- to exchange information regarding my participation in Pre-ETS, to the extent it facilitates cooperation between the school, a Pre-ETS provider, and OVR regarding scheduling of services.

I release the above entity that disclosed this information from any legal responsibility or liability for disclosure of the information to the extent the information was used for its stated purposes.

This authorization or a true and accurate copy of this authorization shall be considered valid until withdrawn in writing by my personal representative or me or I exit high school. If student is under the age of 18, a parent or guardian signature is required.

- If necessary to accommodate my needs, an alternative format of this authorization has been provided to me.

\_\_\_\_\_  
Student Signature Date

\_\_\_\_\_  
Parent/Guardian Name (Print) Parent/Guardian Signature Date

- A verbal consent requires two (2) witness signatures. I witness that a parent/student (or responsible person) is unable to provide a signature but understands the nature of the release and freely gives his/her consent.

\_\_\_\_\_  
First witness signature Date

\_\_\_\_\_  
Second witness signature Date

## AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

Reset Form

Print Form

PID: \_\_\_\_\_

CID: \_\_\_\_\_

SCHOOL				STUDENT			
NAME				NAME			
MAILING ADDRESS				MAILING ADDRESS			
CITY				CITY			
STATE				STATE		ZIP CODE	
STATE		ZIP CODE		DATE OF BIRTH		EXPECTED GRADUATION YEAR	

I hereby authorize the release of any or all of the above referenced student's records and/or grades, as requested to the Office of Vocational Rehabilitation.

I release the above entity that disclosed this information from any legal responsibility or liability for disclosure of the above information to the extent that the information was used for its stated purposes.

This authorization or a photographic copy of this authorization shall be valid for one year from the date of signature unless withdrawn in writing by me or my personal representative.

I certify that I have read and fully understand the foregoing statements.

CLIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

(If applicable)

Please initial if this statement is applicable:

\_\_\_\_\_ If necessary to accommodate my needs, an alternative format of this authorization has been provided to me.

INFORMATION REQUESTED:	PLEASE SEND INFORMATION TO:									
<input type="checkbox"/> Psychological Evaluation Reports <input type="checkbox"/> Most Recent IEP <input type="checkbox"/> Vocational Evaluations/Assessments <input type="checkbox"/> Transcripts <input type="checkbox"/> Initial and Most Recent Evaluation Report (ER) <input type="checkbox"/> Summary of Performance (SoP) <input type="checkbox"/> Records of Community Based Instruction/Evaluations <input type="checkbox"/> Copy of Student's Photo ID <input type="checkbox"/> Assistive Technology (AT) Evaluation <input type="checkbox"/> Description of Current Accommodations/Support/AT <input type="checkbox"/> Other: _____	<p>OVR REPRESENTATIVE <i>Kim Ragan</i></p> <p>MAILING ADDRESS <i>201 W. Whaling St</i></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">CITY <i>Washington</i></td> <td style="width: 33%;">STATE <i>PA</i></td> <td style="width: 33%;">ZIP CODE <i>15301</i></td> </tr> <tr> <td>PHONE NUMBER <i>724-531-1352</i></td> <td colspan="2">FAX NUMBER <i>724-223-4463</i></td> </tr> <tr> <td colspan="3">EMAIL <i>Kragan@pa.gov</i></td> </tr> </table>	CITY <i>Washington</i>	STATE <i>PA</i>	ZIP CODE <i>15301</i>	PHONE NUMBER <i>724-531-1352</i>	FAX NUMBER <i>724-223-4463</i>		EMAIL <i>Kragan@pa.gov</i>		
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EMAIL <i>Kragan@pa.gov</i>										

Auxiliary aids and services are available upon request to individuals with disabilities.  
Equal Opportunity Employer/Program

Department of Labor & Industry  
Office of Vocational Rehabilitation

### CUSTOMER REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

I have been informed that the Office of Vocational Rehabilitation (OVR) has an obligation to keep my personal information and my records confidential. I have also been informed that I may choose to allow OVR to release any part or all of my personal and my record information to designated individuals or agencies. By completing and signing this form, I am authorizing release of specific information to a designated individual[s].

\_\_\_\_\_, authorize OVR to share the following specific information with:

Customer Name

Name/Agency: \_\_\_\_\_

Phone: \_\_\_\_\_

Address:

with copies of documents as may be listed below. For the time period of \_\_\_\_\_ to \_\_\_\_\_.

What information about me I want shared. List as specifically as possible, i.e. name, dates of service, specific documents, forms, etc. If HIV/AIDS or Drug/Alcohol related information is to be released it must be indicated specifically in this section. If psychiatric/Psychological records are to be released they must be indicated specifically in this section.

Why I want my information shared. List as specifically as possible, i.e. to receive benefits, to gain employment, etc. [This section is optional.] :

*Eligibility / Service Delivery*

I understand that this release is valid when I sign it and remains effective for a period of one (1) year from the date of my signature. Additionally, I understand that I may withdraw my consent to this release at any time either orally or in writing.

I further certify my understanding that OVR is not responsible for and cannot safeguard the confidentiality of information disclosed to third parties pursuant to this authorization.

Customer/Parent/Responsible Party

Date

*Kimberly A. Ragan, VRC*

OVR Counselor

Date

**Reaffirmation and Extension** (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until \_\_\_\_\_ (Date).

Customer/Parent/Responsible Party

Date

**FINANCIAL NEEDS TEST (FNT)**

Name: \_\_\_\_\_ Case ID Number: \_\_\_\_\_

Number of Dependents in Your Family Excluding Yourself..... \_\_\_\_\_

Adjusted Gross Annual Income.....\$ \_\_\_\_\_

Less Exceptional Expenses.....\$ \_\_\_\_\_

Financial Needs Test Income.....\$ <sup>0</sup> \_\_\_\_\_

Less Income Allowance.....\$ 100,000 \_\_\_\_\_

Subtotal.....\$ <sup>0</sup> \_\_\_\_\_

Less \$5,140 per Dependent (excluding yourself).....\$ <sup>0</sup> \_\_\_\_\_

Financial Needs Test Income.....\$ <sup>0</sup> \_\_\_\_\_

x Contribution Rate 10%.....\$ <sup>0</sup> \_\_\_\_\_

Based on this Financial Needs Test you are expected to contribute.....\$ <sup>0</sup> \_\_\_\_\_

toward the cost of authorized services for a twelve month period beginning with the first service authorized. Your entire contribution will be spent for cost services before OVR will spend money on your behalf.

Documentation of Income and Exceptional Expenses seen by Counselor: \_\_\_\_\_

**I affirm that the information on income and exceptional expenses by me is true and accurate to the best of my knowledge.**

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse, Parent/Guardian, Responsible Person Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

**INDIVIDUALIZED PLAN FOR  
EMPLOYMENT**

**PARTICIPANT NAME:** \_\_\_\_\_ **PID:** \_\_\_\_\_ **CASE ID:** \_\_\_\_\_

**PLAN INFORMATION**

<b>*PLAN TYPE</b> <input type="checkbox"/> Initial Plan <input type="checkbox"/> Plan Amendment	<b>PLAN EFFECTIVE DATE</b>  
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**GOAL DETAILS**

<b>*GOAL TYPE</b> <input type="checkbox"/> CIE <input type="checkbox"/> Supported Employment for CIE		
<b>*OCCUPATIONAL GOAL</b>  	<b>*SPECIFIC JOB GOAL</b>  	<b>O*NET CODE</b>  

**EMPLOYMENT DETAILS**

<b>*IS THE CUSTOMER CURRENTLY EMPLOYED?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**PLANNED SERVICES**

<b>SERVICE NAME:</b> Vocational Guidance and Counseling
<b>SERVICE PROVISION CATEGORY:</b>
<b>HOW SERVICE OBTAINED:</b> OVR
<b>COMPARABLE BENEFITS:</b> NO
<b>PROVIDER/ENTITY:</b> OVR Sole Provider
<b>ESTIMATED START-END DATE:</b>
<b>CRITERIA FOR MAKING PROGRESS TOWARD SERVICE:</b> *Vocational Guidance and Counseling will continue until you have reached your vocational goal. Progress in C&G services will be evaluated through your participation in counseling sessions with your VRC until your functional limitations have lessened and you are able to obtain and maintain employment for 90 days.
<b>SERVICE NAME:</b> Secondary Training (High School)
<b>SERVICE PROVISION CATEGORY:</b>
<b>HOW SERVICE OBTAINED:</b> _____ School District
<b>COMPARABLE BENEFITS:</b> YES
<b>PROVIDER/ENTITY:</b> _____ School District
<b>ESTIMATED START-END DATE:</b>
<b>CRITERIA FOR MAKING PROGRESS TOWARD SERVICE:</b> *Progress in your transition services will be measured through VRC's review of quarterly grades, OVR job goal research assignment, as well as a copy of your diploma demonstrating your progress towards meeting credit requirements for graduation school by _____



PARTICIPANT NAME: \_\_\_\_\_

PID: \_\_\_\_\_

CASE ID: \_\_\_\_\_

**PLANNED SERVICES (CONTINUED)**

SERVICE NAME: Pre Ets Services- Job Shadowing, PWE, PCE, PCF, MWI

SERVICE PROVISION CATEGORY:

HOW SERVICE OBTAINED: OVR

COMPARABLE BENEFITS: NO

PROVIDER/ENTITY:

ESTIMATED START-END DATE:

**CRITERIA FOR MAKING PROGRESS TOWARD SERVICE:**

\*Progress in your Pre Employment Transition services will be evaluated by your VRC through monthly progress reports demonstrating your active participation in placement development, and acquisition of work skills which will be received from your Pre-Ets Provider.

SERVICE NAME: Job Placement/Job Search Assistance

SERVICE PROVISION CATEGORY:

HOW SERVICE OBTAINED: OVR/Career LINK

COMPARABLE BENEFITS: YES

PROVIDER/ENTITY: OVR/Career Link

ESTIMATED START-END DATE:

**CRITERIA FOR MAKING PROGRESS TOWARD SERVICE:**

Job Placement services will be concluded once you have reached your vocational goal and remain successfully employed for at least 90 days.

SERVICE NAME:

SERVICE PROVISION CATEGORY:

HOW SERVICE OBTAINED:

COMPARABLE BENEFITS:

PROVIDER/ENTITY:

ESTIMATED START-END DATE:

**CRITERIA FOR MAKING PROGRESS TOWARD SERVICE:**

**PLANNED SERVICES — ADDITIONAL DETAILS**

<p><b>*ARE ONGOING EMPLOYMENT SERVICES ANTICIPATED?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>*HOW SERVICE OBTAINED</b></p> <p><input type="checkbox"/> Provided by the VR Agency (in-house by OVR Staff)</p> <p><input type="checkbox"/> Purchased by the VR Agency</p> <p><input type="checkbox"/> Provided by Comparable Services &amp; Benefits Providers</p> <p><input type="checkbox"/> Not Provided</p>	<p><b>PROVIDER/ENTITY NAME</b></p>
<p><b>*PARTICIPANT IS ELIGIBLE FOR SOCIAL SECURITY BENEFITS COUNSELING AND DECLINED SERVICES</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Not Applicable</p>		



PARTICIPANT NAME: \_\_\_\_\_

PID: \_\_\_\_\_

CASE ID: \_\_\_\_\_

## PLAN RESPONSIBILITIES

- \* Contact VRC on agreed dates/times for monthly counseling sessions. Notify counselor of any changes in your current situation that will impact employment.
- \* Provide copies of your grades quarterly and copy of your diploma within 2 weeks of receipt and complete all graduation requirements.
- \* You will be referred to Pre-employment transition services with the provider of your choice. Work with you provider to secure placement, follow all directives given, arrive on time as scheduled and perform to the best of your abilities. If you experience any issues or problems contact your counselor.
- \*\* Utilize OVR and Career Link in your job search, participate in all job search activities, and keep a monthly log of your job search activities.

## ANTICIPATED EXTENDED SERVICES

SERVICE PROVIDER/ENTITY	IF OTHER, SERVICE PROVIDER/ENTITY
SERVICE PROVIDER/ENTITY DETAILS	

## PLAN ACTIONS

NEW CASE STATUS CODE	PARTICIPANT ACCOMMODATION	PARTICIPANT ACCOMMODATION SATISFIED

## UNDERSTANDINGS

### YOUR RESPONSIBILITIES

You must cooperate in carrying out the IPE and make reasonable efforts to attain your job goal. You must utilize comparable benefits for applicable services; you must pay for cost services in accordance with the financial needs test.

### YOUR RIGHTS AND REMEDIES

Your OVR counselor will assist you in completing the IPE and obtaining appropriate services. However, you may develop your IPE yourself, with the assistance of the OVR counselor, or the assistance of another person or agency you choose. OVR will not pay for another person or agency to assist you. You have the opportunity to choose your job goal, services and the service provider. OVR services will be provided in the most integrated settings possible, consistent with informed choice, and in accordance with Commonwealth and OVR purchasing policies. Your IPE must be approved and signed by the OVR counselor. The OVR counselor must also approve any substantial changes in your job goal, services, and service providers. You will then prepare an IPE amendment with your OVR counselor. You and your OVR counselor must review your IPE annually.

You may discuss a problem or grievance with your OVR counselor. If you disagree with a decision made by OVR, you may appeal the decision. The appeal must be mailed to the Central Office Appeals Officer, 651 Boas Street, 7th Floor, Harrisburg, PA 17121. The appeal shall state the reason for the appeal and the action, services or relief you want; and be sent within thirty (30) days of the decision with which you are dissatisfied.

If you become ineligible, you will have the opportunity for full consultation in such a decision. If ineligible because you cannot benefit from OVR services, you will have the opportunity to participate in an annual review within 12 months of that decision and thereafter at your request.

PARTICIPANT NAME: \_\_\_\_\_ PID: \_\_\_\_\_ CASE ID: \_\_\_\_\_

**CLIENT ASSISTANCE PROGRAM (CAP) INFORMATION**

If you have questions or concerns about OVR services, CAP can help. CAP is a federally mandated program that provides assistance and advocacy to applicants for and recipients of OVR services. CAP is not a part of OVR, and services are provided at no cost to its clients. Contact CAP: by phone at 215-557-7112 (voice/711Relay) or 888-745-2357 (voice/711Relay); by fax at 215-557-7602; by email at admin@equalemployment.org; by submitting an inquiry on the CAP website at <https://equalemployment.org/>; or by mail to Client Assistance Program, 101 Greenwood Avenue, Suite 470, Jenkintown, PA 19046. CAP contacts are kept confidential.

**CONFIDENTIALITY**

All information acquired as part of the OVR process shall remain the property of OVR. It is strictly confidential. Information shall be used only for purposes directly related to the administration of your OVR program. This information will not be shared with anyone except Pennsylvania OVR staff or other agencies with whom OVR has a written cooperative agreement without your informed written consent or that of your representative, unless required by law.


**TICKET TO WORK PROGRAM**

I agree and acknowledge that by signing the Individualized Plan for Employment (IPE) my Ticket to Work will be put "In Use-SVR" with the Office of Vocational Rehabilitation on the date I sign the IPE.

**The Individualized Plan for Employment (IPE) is not a legal contract.  
The IPE may be subject to administration approval and the availability of funds.**

**SIGNATURES**

I have participated in the development of this OVR plan and I understand and accept its provisions.

Participant, if over 18	Date	Parent/Guardian/Responsible Party, if participant under age 18	Date
Person Assisting Participant	Date		
 VR Counselor	Date	VR Supervisor (if applicable)	Date