State of Delaware | Department of Labor
Division of Vocational Rehabilitation

Application for DVR Employment Services

This is a confidential communication

FOR OFFICE USE ONLY

Intake Date: ____________

Counselor: ____________

Participant #: ____________

The Division of Vocational Rehabilitation's (DVR) main focus is to partner with people with disabilities who are seeking employment and help them develop a career pathway to find long term, meaningful employment. Please complete all fields of this application. Thank you for your help.

Last Name:		**First Name:**	**MI:**
Preferred/Nickname:		**Previous Last Name:**	
Physical Address:			
City:	**State:**	**Zip Code:**	**County:**
Mailing Address (if different from Physical Address):			
City:	**State:**	**Zip Code:**	**County:**
Telephone Number:	**Cell Phone Number:**	**Alternate Phone Number:**	
Email Address:			
Social Security Number:		**Date of Birth:**	

What are your disabilities?
How do your disabilities affect your ability to work?

Race (Check all that apply):	**Ethnicity: Are you Hispanic/Latino?**	**Marital Status:**	
☐ White/Caucasian ☐ American Indian Or Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander	◯ Yes ◯ No **Gender:** ◯ Female ◯ Male	☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed	**Are you a U.S. Citizen?** ◯ Yes ◯ No **If you answered no, are you legally able to work in the U.S.?** ◯ Yes ◯ No **Are you a veteran?** ◯ Yes ◯ No

Emergency Contact (Someone who will know how to contact you):			
Name:		**Relationship to you:**	
Primary Phone:		**Secondary Phone (Cell):**	
Physical Address:			
City:	**State:**	**Zip Code:**	**County:**

What are your current living arrangements?

- ☐ Private Residence (Independent, Family, etc.)
- ☐ Substance Abuse Treatment Facility
- ☐ Community/Group Home
- ☐ Adult Correctional Facility
- ☐ Halfway House
- ☐ Rehabilitation Facility
- ☐ Homeless Shelter
- ☐ Nursing Home
- ☐ Other: ______________________

Who provides most of the money you need to support yourself?

- ☐ Own personal income
- ☐ Public Support (SSI, SSDI, TANF, etc.)
- ☐ Family/Friends
- ☐ Other

If Other: ______________________

Number of Dependents: __________ Gross Monthly Family Income: __________

How much money do you receive from these sources per month?

SSI	________	SSDI	________	SSA Retirement benefits	________
TANF	________	VA Disability	________	Other Public Support	________
General Assistance	________	Worker's Compensation	________	If Other Support:	________

Do you have medical insurance? Please check all that apply.

Yes	No	Medicaid	Medicare	Public, via other sources	Private, via my employer	Private, via other means
☐	☐	☐	☐	☐	☐	☐

Primary Insurance Carrier:	Policy Number:	Secondary Insurance Carrier:	Policy Number:

Highest Level of Education:

- ☐ No Formal Education
- ☐ Elementary Education (Grades 1-8)
- ☐ Secondary Education, No HS Diploma (Grades 9-12)
- ☐ Special Education Certificate or Completion of Attendance
- ☐ High School Graduate or Equivalency Certificate
- ☐ Post-Secondary Education, No Degree
- ☐ Associate's Degree or Vocational Certificate
- ☐ Bachelor's Degree
- ☐ Master's Degree or Higher

Name of high school you attend/attended: ______________________

Are you currently a high school student? ○ Yes ○ No

Post-Secondary Education school attended: ______________________

Associate's/Vocational Cert. school attended: ______________________ Date of Graduation: __________

Bachelor's Degree school attended: ______________________ Date of Graduation: __________

Master's Degree or higher school attended: ______________________ Date of Graduation: __________

Do you have an IEP? ○ Yes ○ No

Do you have a 504? ○ Yes ○ No

Current Employment Status:

- ○ Employed - Full Time
- ○ Homemaker
- ○ Employed - Part Time
- ○ Self-Employed
- ○ Workshop/Shelter
- ○ Unpaid Family Worker
- ○ Migrant Seasonal Farm Worker
- ○ Not Employed - Trainee or Voluteer
- ○ Not Employed - Post Secondary Student
- ○ Not Employed - Other

If employed, what is your current salary?

Hours/Week: __________

Earnings/Week: __________

When were you last employed?

Month/Year: __________

Are you registered to vote? ○ Yes ○ No

If no, would you like to be? ○ Yes ○ No

Please discuss your current skills, abilities and job interests?

Work History

Employer Name:				Employment Start	Employment End
Employer Address:					
City:			State:		Zip Code:
Your Job Title:		Supervisor:		Telephone Number:	
Job Duties:					
Hours/Week:	Salary:	Reason for Leaving:			

Employer Name:				Employment Start	Employment End
Employer Address:					
City:			State:		Zip Code:
Your Job Title:		Supervisor:		Telephone Number:	
Job Duties:					
Hours/Week:	Salary:	Reason for Leaving:			

Employer Name:				Employment Start	Employment End
Employer Address:					
City:			State:		Zip Code:
Your Job Title:		Supervisor:		Telephone Number:	
Job Duties:					
Hours/Week:	Salary:	Reason for Leaving:			

Employer Name:				Employment Start	Employment End
Employer Address:					
City:			State:		Zip Code:
Your Job Title:		Supervisor:		Telephone Number:	
Job Duties:					
Hours/Week:	Salary:	Reason for Leaving:			

Who referred you to DVR?

- ☐ Educational Institution (Elementary/Secondary)
- ☐ Education Institution (Post-Secondary)
- ☐ Community Rehabilitation Program
- ☐ Welfare Agency
- ☐ Social Security Administration
- ☐ One-Stop Employment Center
- ☐ Physician or Other Medical Personnel
- ☐ Private Residence (Family, Independent, etc.)
- ☐ Self-Referral
- ☐ Other Source

If Other Source, where? ______________________________

Are you currently working with any of the following agencies?

- ☐ American Indian VR Services Program
- ☐ Center for Independent Living
- ☐ Child Protective Services
- ☐ Community Rehabilitation Program
- ☐ Consumer Organization or Advocacy Group
- ☐ Education Institution (elementary/secondary)
- ☐ Educational Institution (post-secondary)
- ☐ Employer
- ☐ Employment Network
- ☐ Federal Student Aid (Pell grant, SEOG, work study, etc)
- ☐ Intellectual & Developmental Disabilities Agency
- ☐ Medical Health Provider (Public or Private)
- ☐ Mental Health Provider (public or private)
- ☐ No Service or Funding Provided
- ☐ One-stop Employment/Training Center
- ☐ Other Source
- ☐ Other State Agency
- ☐ Other VR State Agency
- ☐ Public Housing Authority
- ☐ SSA (Disability Determination Service or district office)
- ☐ State Department of Correction/Juvenile Justice
- ☐ State Employment Service Agency
- ☐ Veterans Administration
- ☐ Welfare Agency (state or local government)
- ☐ Workers Compensation

Applicant Signature:	**Date:**
Parent/Guardian Signature (if applicant is under 18 years of age or has a legal guardian)	**Date:**
Counselor Signature:	**Date:**

Rev. 2016/04