DWS-USOR 4
Rev. 04/2019

State of Utah
Department of Workforce Services

VOCATIONAL REHABILITATION APPLICATION AND RELEASE OF INFORMATION

APPLICANT INFORMATION

Social Security number: _____

Last name: _____ First name: _____ Middle initial: _____

Gender: ☐ Male ☐ Female ☐ I choose not to disclose Birth date: ____/____/_____

Home address: _____

City: _____ State: _____ ZIP code: _____

Mailing Address:
(if different from home) _____

City: _____ State: _____ ZIP code: _____

Primary phone: _____ Secondary phone: _____

Email: _____

RACE (SELECT ALL THAT APPLY)

☐ Black/African American
☐ White/Caucasian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Asian
☐ I choose not to identify

ETHNICITY

☐ Hispanic/Latino
☐ Not Hispanic/Latino

LANGUAGE

☐ ASL ☐ English ☐ Spanish

☐ Other (specify): _____

COMMUNICATION PREFERENCE

☐ ASL
☐ Audio tape
☐ Braille
☐ Large print
☐ Minimal language skills
☐ Oral
☐ Tactile
☐ Total communication

Specific communication needs: _____

VETERAN STATUS

Veteran: ☐ Yes ☐ No Type of discharge: _____

LIVING ARRANGEMENT

☐ Private residence (by yourself, with family or others)
☐ Adult/youth correctional facility
☐ Community residential/group home
☐ Homeless shelter
☐ Halfway house
☐ Substance abuse treatment center
☐ Mental health facility
☐ Nursing home
☐ Rehabilitation facility
☐ Other (specify): _____

MARITAL STATUS

☐ Married ☐ Never married ☐ Divorced ☐ Separated ☐ Widow

U.S. CITIZENSHIP

****IF NOT A US CITIZEN PLEASE BRING USCIS CARD WITH YOU TO YOUR APPOINTMENT****

☐ Yes, I am a U.S. citizen

☐ Not a U.S. citizen but I have a USCIS Permanent Resident Card

☐ Not a U.S. citizen but I have a USCIS Employment Authorization Card

☐ Not a U.S. citizen, other

****BRING PHOTO ID**** ID # _____

REFERRAL SOURCE

Who referred you to VR? _____

What is the reason they suggested you should apply? _____

FINANCIAL

What is your main source of financial support at this time? _____

IF YOU RECEIVE ANY OF THE FOLLOWING BENEFITS, PLEASE ESTIMATE THE AMOUNT BELOW

☐ SSI aged $ _____ ☐ SSI blind $ _____ ☐ SSI disabled $ _____

☐ SSDI disabled $ _____ ☐ Veteran's disability benefits $ _____

☐ General Assistance $ _____ ☐ Other (specify): _____

MEDICAL INSURANCE

☐ Medicaid ☐ Medicare ☐ Other public (PCN, WC etc.) ☐ No insurance

☐ Private through employer ☐ Other private insurance ☐ Not eligible through employer

EMPLOYMENT HISTORY

**** IF YOU HAVE A RESUME, PLEASE BRING A COPY TO YOUR APPOINTMENT. IN ADDITION, PLEASE COMPLETE THE EMPLOYMENT HISTORY BELOW****

Are you currently employed? ☐ Yes ☐ No

LIST WORK HISTORY, IN ORDER, BEGINNING WITH YOUR MOST RECENT JOB

Job title: _____ Start date: _____ Hours worked per week: _____

Salary: _____ Employer: _____ Date ended: _____

Employer address: _____

City: _____ State: _____ ZIP: _____

Job duties: _____

_____

_____

Reason job ended: _____

Job title: _____ Start date: _____ Hours worked per week: _____

Salary: _____ Employer: _____ Date ended: _____

Employer address: _____

City: _____ State: _____ ZIP: _____

Job duties: _____

_____

_____

Reason job ended: _____

Job title: _____ Start date: _____ Hours worked per week: _____

Salary: _____ Employer: _____ Date ended: _____

Employer address: _____

City: _____ State: _____ ZIP: _____

Job duties: _____

_____

_____

Reason job ended: _____

CONTACTS

Emergency contact: _____ Phone number: _____

Non-family contact: _____ Phone number: _____

Legal guardian: _____ Phone number: _____

Other contact: _____ Phone number: _____

Probation or parole officer: _____ Phone number: _____

****IF YOU HAVE A LEGAL HISTORY, PLEASE BRING INFORMATION (CHARGES/DATES) TO YOUR APPOINTMENT TO DISCUSS WITH YOUR COUNSELOR****

EDUCATION

What is your highest level of education? _____ When did you last attend school? _____

Are you currently enrolled in school? _____

If yes, what is the name of the school? _____

If in school, who is your primary school contact? _____

Do you hold any current certifications? _____

ARE YOU A STUDENT WITH DISABILITY IN SECONDARY EDUCATION

☐ High school student with an IEP ☐ High school student with a 504 plan ☐ High school student with IEP & 504 plan

IF YOU ARE CURRENTLY TAKING MEDICATIONS, LIST THEM BELOW

1. _____ Reason prescribed: _____
2. _____ Reason prescribed: _____
3. _____ Reason prescribed: _____
4. _____ Reason prescribed: _____

Are you currently taking your prescribed medications? ☐ Yes ☐ No

If not, why? _____

****LIST ANY ADDITIONAL MEDICATIONS AND THE REASON YOU ARE PRESCRIBED THEM ON A SEPARATE SHEET OF PAPER FOR YOUR COUNSELOR****

MEDICAL RECORD INFORMATION

Name of treatment provider (doctor, psychologist, other) who knows about your disability:

Dates of treatment: _____

Phone number: _____ Fax number: _____

Address: _____ State: _____ ZIP code: _____

Reason for treatment: _____

Name of treatment provider (doctor, psychologist, other) who knows about your disability:

Dates of treatment: _____

Phone number: _____ Fax number: _____

Address: _____ State: _____ ZIP code: _____

Reason for treatment: _____

Name of treatment provider (doctor, psychologist, other) who knows about your disability:

Dates of treatment: _____

Phone number: _____ Fax number: _____

Address: _____ State: _____ ZIP code: _____

Reason for treatment: _____

DISABILITY INFORMATION

What is your current disability(ies)? _____

How does the disability(ies) affect your ability to work?

COUNSELOR NOTES:

Sign the application after reading the following information.

GATHERING INFORMATION TO DETERMINE ELIGIBILITY: The information contained in this application is true and correct to the best of my knowledge. Permission is granted to the Utah State Office of Rehabilitation to make whatever inquiries might be necessary to verify these statements including the sharing of information with the Department of Workforce Services. In applying for Vocational Rehabilitation Services, I understand there is a need to collect personal information. The authority to collect this information comes from Federal Regulation 34 CFR 361.38(a) (1) (iii). I understand that collecting this information is necessary to determine eligibility and therefore is mandatory. Failure to provide requested information may result in a determination of not being eligible for Vocational Rehabilitation Services. I understand that my counselor has 60 days from the date I submit a complete application to determine eligibility, but that circumstances may arise where this information cannot be acquired within this time frame. I agree to sign a request to extend the time for determination of eligibility if I want to have the 60 days extended.

SOCIAL MEDIA: I understand that, in connection with furnishing me with Vocational Rehabilitation services, my counselor may access or view my social media profiles and posts.

CONFIDENTIALITY: I understand that information concerning me is confidential and protected under State & Federal regulations as well as professional codes of ethics governing confidentiality. I recognize this information cannot be disclosed without my written consent, unless otherwise provided for in the State and Federal regulations. However, I understand that, by signing this form, I am agreeing that information about me may be released to appropriate agencies or individuals without my informed consent in order to accomplish my vocational rehabilitation plan and job placement goals and I understand these agencies and/or individuals will be made known to me. I authorize the exchange of information between the Utah State Office of Rehabilitation and other entities, including the Department of Workforce Services, only for the use of the Utah State Office of Rehabilitation as needed to determine eligibility and appropriate services and for the administration of their program. I further understand that, at the time my Vocational Rehabilitation case is closed, my contact information may be referred to an Employment Network that has partnered with the Utah State Office of Rehabilitation under a Partnership Plus arrangement for the purpose of providing and coordinating further services I may be eligible to receive.

IN CASE OF A PROBLEM: I understand that a Client Assistance Program (CAP) representative is available to act as my advisor and advocate at any time, and that I may call toll free (1-800-

662-9080) to reach the Client Assistance Program (CAP) located at 205 North 400 West, Salt Lake City, Utah 84103.

I understand that I have the opportunity for a timely review of any determination by my rehabilitation counselor. If I am dissatisfied with the furnishing or denial of Vocational Rehabilitation services, I may request a written or verbal review of a determination, or mediation regarding a determination, to my counselor, the immediate supervisor, the District Director, or to: **Division of Rehabilitation Services, Administration Office, 1595 W 500 S, P.O. Box 144200, Salt Lake City, Utah 84114-4200.** If I request mediation, my mediator will be chosen randomly from a list of qualified mediators unless the Utah State Office of Rehabilitation and I agree to use a particular mediator. If I request a hearing, the hearing officer will be chosen randomly from a list of qualified Administrative Law Judges unless the Utah State Office of Rehabilitation and I agree to use a particular hearing officer.

NO DISCRIMINATION: I understand that services in this program are provided without regard to sex, race, age, religion, color, or national origin according to Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act. The agency also assures that no group of individuals will be excluded or found ineligible solely on the basis of type of disability.

I understand that altering this application in any way will make it invalid and I have completed this application in its original form. I understand that I must provide proof of identity and must be able to be legally employed in the United States. I have read (or have had read to me) and understand and agree to the above.

Signature of Applicant/Representative	**Date**
Parent Signature (if applicant is a minor)	**Date**
Counselor Signature (reviewed and accepted)	**Date**

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02/2019

State of Utah
Department of Workforce Services
VOTER REGISTRATION REQUEST

If you are not registered to vote where you live now, would you like to apply to register or preregister to vote here today?

(The decision of whether to register or preregister to vote will not affect the amount of assistance that you will be provided by this agency.)

☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER OR PREREGISTER TO VOTE AT THIS TIME.

If you would like help in filling out the voter registration form, we will help you. The decision about whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or preregister or to decline to register or preregister to vote, your right to privacy in deciding whether to register or preregister, or in applying to register or preregister to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Office of the Lieutenant Governor, State Capitol Building, Salt Lake City, Utah 84114.

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State of Utah
Department of Workforce Services
Utah State Office of Rehabilitation

SERVICE COORDINATION CONSENT

Client Name: _____

Access to records and case information is restricted under state and federal privacy laws and cannot be disclosed without my written consent, unless otherwise authorized by law. I understand that a failure to sign this consent will in no way impact any services for which I may be eligible.

By signing this form, I authorize the Utah Department of Workforce Services (DWS) to release, disclose and share my information for purposes of coordinating a variety of services provided to individuals by the State of Utah and other authorized partners. Specifically, information may be shared with the **Utah Department of Corrections**, the **Utah Department of Human Services**, **the Utah Governor's Office of Management and Budget**, and the **Utah Department of Technology Services**. Information disclosed may include, but is not limited to, my personal information, such as my name, address, date of birth, case type, etc. Information disclosed may also include information about my DWS counselor and DWS plan components, such as my employment goals, activities, and progress notes. Representatives of these agencies may also share information with DWS to improve coordination of services.

I understand that state and federal privacy laws may no longer protect information that has been released to other entities, and the Department of Workforce Services cannot prevent this information from being re-disclosed.

I understand that this authorization does NOT authorize the disclosure of records classified as protected or controlled under GRAMA, the Government Records Access and Management Act.

I understand that I may revoke this authorization at any time.

Client/Parent/Guardian Signature: _____

Date: _____