Nevada Department of Employment, Training and Rehabilitation
Application for Vocational Rehabilitation Services

Social Security Number	Case # (Office Use Only)

Last Name	First Name	MI	Previous Name(s)

Current Street Address	Apt	City	State	Zip Code

Mailing Address (If Different)	City	State	Zip Code

County	Telephone	Cell Phone	Date of Birth
	( )	( )	

Email Address	

Veteran Status

- ☐ Not a Veteran
- ☐ Active Service (>180 Days)
- ☐ Active Service (≥180 Days)
- ☐ Spouse of Veteran
- ☐ Does Not Wish To Disclose

Are You a US Citizen?

☐ Yes ☐ No

Alien Registration Card?

☐ Yes ☐ No

Employment Authorization Document?

☐ Yes ☐ No

Race / Ethnicity (At Least One)

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic / Latino
- ☐ Native Hawaiian / Pacific Islander
- ☐ White

Transition / Training (Students Only)

Current Grade Level _____

School Name _____

County _____

Out of State School _____

(If attending a school outside of Nevada)

For Office Use Only - Received By:

_____ _____

Agency Representative Date Received

Contact Name and Telephone Number

Enter the contact information for someone whose phone number is different than yours and who would give you a message.

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Enter the contact information for someone NOT living in your home.

Name _____ Relation _____ Phone _____

Language Abilities (Check One For Each Option)

English Reading ☐ Functional ☐ Limited ☐ Unknown

English Speaking ☐ Functional ☐ Limited ☐ Unknown

Primary Language _____

Gender

☐ Male

☐ Female

☐ Doesn't Wish To Self-Identify

Who Referred You?

☐ Social Security or Disability Determination Services

☐ Law Enforcement, Correction or Court System

☐ University, College, Technical or Vocational School

☐ Grade School or High School

☐ Job Connect or Worker's Compensation

☐ Self-Referral, Friend or Family

☐ Veteran's Administration

☐ Doctor, Hospital or Mental Health Facility

☐ Rehabilitation Program in Your Community

☐ Welfare or Public Assistance Agency

Current Living Arrangement

- ☐ Private Residence (Home, With Family or Roommate)
- ☐ Mental Health Facility
- ☐ Substance Abuse Treatment Center
- ☐ Group Home
- ☐ Nursing Home
- ☐ Halfway House
- ☐ Rehabilitation Facility
- ☐ Jail / Adult Correctional Facility
- ☐ Homeless or Shelter
- ☐ Other

Marital Status

- ☐ Single
- ☐ Divorced
- ☐ Married
- ☐ Widowed
- ☐ Separated

Voting Status

- ☐ Currently Registered
- ☐ Not Eligible
- ☐ Not Interested

Want to Register to Vote Today?

☐ No ☐ Yes ☐ Form # _____

County Served In

- ☐ Carson City
- ☐ Churchill
- ☐ Clark
- ☐ Douglas
- ☐ Elko
- ☐ Esmeralda
- ☐ Eureka
- ☐ Humboldt
- ☐ Lander
- ☐ Lincoln
- ☐ Lyon
- ☐ Mineral
- ☐ Nye
- ☐ Pershing
- ☐ Storey
- ☐ Washoe
- ☐ White Pine

Household Information

Gross Monthly Family Income $ _____

Parents Monthly Income (If Under Age 18) $ _____

Total Number in Family / Household _____

Total Number of Dependents in Family _____

Household Information - Continued

Name _____ Age _____ Relation _____ Occupation _____

Name _____ Age _____ Relation _____ Occupation _____

Name _____ Age _____ Relation _____ Occupation _____

Name _____ Age _____ Relation _____ Occupation _____

Name _____ Age _____ Relation _____ Occupation _____

Primary Source of Income

- ☐ Personal Income (Earnings, Interest, Dividends, Rent)
- ☐ Spouse's Income or Support From Family and Friends
- ☐ Public Institution - Tax Supported
- ☐ Public Support (SSDI, SSI, TANF, etc.)
- ☐ Annuity or Non-Disability Benefit
- ☐ Private Relief Agency
- ☐ Worker's Compensation

Medical Insurance

- ☐ Medicaid
- ☐ Medicare
- ☐ Not Yet Eligible
- ☐ Public Insurance From Other Sources
- ☐ Private Insurance Through Own Employment
- ☐ Private Insurance Through Other Means (Spouse / Parent)
- ☐ State or Federal Affordable Care Act Exchange

Insurance Company _____

SSDI (Social Security Disability Insurance) or SSI (Supplemental Security Income)

Not an Applicant ☐ SSDI ☐ SSI

Denied Benefits ☐ SSDI ☐ SSI

SSDI (Social Security Disability Insurance) or SSI (Supplemental Security Income)

Allowed Benefits	☐	SSDI	☐	SSI
Application Pending	☐	SSDI	☐	SSI
Benefits Terminated	☐	SSDI	☐	SSI
Unknown	☐	SSDI	☐	SSI

Are You Receiving Any of the Following? If Yes, List Monthly Amount

- ☐ SSDI (Social Security Disability Insurance) $ _____
- ☐ SSI (Supplemental Security Income) $ _____
- ☐ TANF (Temporary Assistance to Needy Families) $ _____
- ☐ General / Public Assistance $ _____
- ☐ Veteran's Disability Benefits $ _____
- ☐ Worker's Compensation $ _____
- ☐ Any Other Type of Public Support (Please Specify) $ _____

Identification: Please Provide Verification for the Following Identification

List A: Provide One Item From This List

List A

- ► United States Passport
- ► Certificate of United States Citizenship
- ► Certificate of Naturalization
- ► Alien Registration Card With Photograph
- ► Unexpired Foreign Passport With Attached Employment Authorization

OR

Lists B and C: Provide One Item From List B **AND** One Item From List C

List B

- ► State Issued Driver's License or State ID Card With Picture and (Name, Sex, Birthdate, Height, Weight and Eye Color)
- ► US Military ID Card

AND

List C

- ► Original Social Security Card to be Witnessed at Intake
- ► Birth Certificate Issued State, County or Municipal Authority
- ► Unexpired INS Employment Authorization

Education: What is Your Highest Level Of Education? Please Check One.

- ☐ No Formal Schooling
- ☐ Elementary Education (Grades 1 - 8)
- ☐ Completed Grade 9
- ☐ Completed Grade 10
- ☐ Completed Grade 11
- ☐ Completed Grade 12 (No High School Diploma)
- ☐ Attained High School Diploma or Equivalency Certificate
- ☐ Still in High School HS Name _____ Grade _____
- ☐ Some Special Education, No Certificate of Completion / Attendance
- ☐ Special Education Certificate of Completion / Attendance
- ☐ Some College, Vocational or Technical, No Degree
- ☐ Attained Vocational / Technical License or Certificate
- ☐ Associate's Degree School _____
- ☐ Bachelor's Degree School _____
- ☐ Master's Degree School _____

While in School, Did You Ever Have:

Individualized Education Program (IEP) ☐ Yes ☐ No

Section 504 Accommodation Plan ☐ Yes ☐ No

Communication Accommodations

Auxiliary aids available upon request if needed for effective communication.

- ☐ Regular Print
- ☐ Braille
- ☐ Large Print
- ☐ ASL Interpreter
- ☐ Other (Please Specify): _____

Primary Means of Transportation

☐ Personal Vehicle ☐ Public Transportation

☐ Other (Please Specify): _____

Work Status at Application

☐ Homemaker ☐ Competitive Employment

☐ Self Employed ☐ Unemployed

☐ Trainee / Intern / Volunteer ☐ Subminimum Wage

Year Last Worked _____

If Employed, How Many Hours Per Week Do You Work? _____

If Employed, What Are Your Gross Weekly Earnings? _____

Felony Information

Have You Ever Been Convicted of a Felony?

☐ Yes ☐ No

Probation Officer _____

Telephone Number _____

Details: _____

How Can The Bureau Be Of Assistance To You? What Employment Related Services Are You Seeking?

Work History and Employment Information

☐ Check Here If No Work History

If working, how many hours per week? _____ Hourly Wage $ _____

Name of Employer _____

Employer Address _____

Job Duties _____

Title of Position Held _____

Reason For Leaving _____

Employment Dates From (Month/Year) _____ To (Month/Year) _____

Name of Employer _____

Employer Address _____

Job Duties _____

Title of Position Held _____

Reason For Leaving _____

Employment Dates From (Month/Year) _____ To (Month/Year) _____

Name of Employer _____

Employer Address _____

Job Duties _____

Title of Position Held _____

Reason For Leaving _____

Employment Dates From (Month/Year) _____ To (Month/Year) _____

Disability and Medical Information

What is the primary medical condition, injury, physical or mental impairment / disability that limits your ability to work?

When did these impairments / disabilities begin (month / year)? _____

- ☐ AIDS / HIV
- ☐ Alcohol or Other Drug Disorder
- ☐ Amputation
- ☐ Arthritis
- ☐ Attention Deficit Disorder
- ☐ Autism
- ☐ Back Injury
- ☐ Blindness or Visual Impairment
- ☐ Brain Injury
- ☐ Cancer
- ☐ Carpal Tunnel (Repetitive Use)
- ☐ Cerebral Palsy (CP)
- ☐ Cognitive Disability
- ☐ Cystic Fibrosis
- ☐ Deaf / Blind
- ☐ Deaf / Hard of Hearing
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hip / Knee / Other Joint Dysfunction
- ☐ Kidney Failure
- ☐ Mental Illness
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Myofascial Disorder
- ☐ Post Paraplegia or Quadriplegic
- ☐ Post Traumatic Stress Disorder
- ☐ Respiratory / Pulmonary / Allergies
- ☐ Severe Arthritis
- ☐ Specific Learning Disability
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Unknown
- ☐ Other: _____

Current Physician / Medical Professional

1. Name and Address _____
   Type of Physician _____
   Phone / Fax _____

2. Name and Address _____
   Type of Physician _____
   Phone / Fax _____

3. Name and Address _____
   Type of Physician _____
   Phone / Fax _____

Hospitalizations

1. Name of Hospital _____
   Hospital Address _____
   Reason _____

2. Name of Hospital _____
   Hospital Address _____
   Reason _____

3. Name of Hospital _____
   Hospital Address _____
   Reason _____

List of Medications

1. Medication Name _____
2. Medication Name _____
3. Medication Name _____
4. Medication Name _____
5. Medication Name _____
6. Medication Name _____

CONFIDENTIAL PERSONAL INFORMATION

The Bureau of Vocational Rehabilitation (Bureau) is a state and federally funded agency that assists persons with disabilities in achieving or maintaining employment. I understand that it is necessary for the Bureau to collect personal information in connection with my rehabilitation program.

- ► I understand that my eligibility and / or provision of services may be impacted if I refuse to provide personal information that is requested by the Bureau.
- ► I understand that my personal information will be held confidential by the Bureau and will not be disclosed to any other person or entity except as noted in the Information and Disclosure Form.

Section 501(b) of the Workforce Innovation and Opportunity Act of 2014; Section 12c of the Rehabilitation Act of 1973 as amended; 29USC711c and 721(a)(6)(A); 34CFR361.38; NRS 426.573, 426.610, 432B.220, 615.280, 615.290 and 629.061.

INACCURATE OR MISLEADING INFORMATION

If you believe that information in your record of services is inaccurate or misleading, you may request that the Bureau amend the information. If the information is not amended, the request for an amendment must be documented in the record of services.

LIABILITY OF STATE FOR THIRD PARTY ACTIONS

The Bureau their officers, agents, employees and elected and appointed officials are not responsible in any manner for damages caused to a client by third-parties, including but not limited to, vendors on an approved list maintained by the Bureau, and hereby specifically disclaim any liability therefore. In addition, the Bureau will not waive and intends to assert available NRS Chapter 41 liability in all cases.

SHARING OF INFORMATION WITH GOVERNMENT ENTITIES

I expressly give my permission for information about me to be shared within the Nevada Department of Employment, Training and Rehabilitation (DETR) and Nevada Department of Education (DOE) as it relates to the administration of the Vocational Rehabilitation program; and to the core programs under the Workforce Innovation and Opportunity Act (WIOA) including DETR, DOE and the Local Workforce Development Boards and the Division of Welfare and Supportive Services (DWSS) for the purposes of coordinating services and comparable benefits. I also understand that Vocational Rehabilitation will have access to information on my Social Security Disability Determination and my employment records.

ACKNOWLEDGEMENT OF ACCEPTANCE

Please initial applicable boxes below and sign the end of the application.

_____ I have been provided the agency's Information and Disclosure Form and informed of:

- My opportunity for review of decisions made by my Rehabilitation Counselor regarding my application, eligibility and the furnishing or denial of service if I do not agree with the decision. This includes information on the Client Assistance Program and the steps I need to take to request a formal appeal of agency decisions.
- My Bill of Rights and Responsibilities.
- The professional qualifications of VR Counselors. I agree to enter into a rehabilitation counseling relationship at this time.
- The protection, use and release of personal information and the conditions under which my personal information may be released without my written consent.
- The risks of electronic communication. I agree to the exchange of information regarding myself through the following methods (initial all that apply):

_____	Telephone	_____	Text
_____	Telephone	_____	Detailed Voice Message
_____	Telephone	_____	Voice Message to Return Call
_____	Telephone	_____	No Voice Message
_____	Email	_____	Do Not Email
_____	Fax	_____	Do Not Fax
_____	Post Mail	_____	To The Address on File
_____	Post Mail	_____	To The Care of My Listed Contacts

In making this application for vocational rehabilitation services, I acknowledge, understand and agree that:

_____ I am applying for vocational rehabilitation services for the specific purpose of getting and/or keeping a job.

_____ VR is largely funded by the federal government and is evaluated on criteria such as the percentage of people who gain work skills or earn credentials (such as a college degree) as well as the percentage of people who maintain employment and earn wages after their case is closed. In order to provide this information, VR must collect data regarding your employment, wages, and credentials obtained. Thus, VR staff or an an automated personal assistant called "SARA" may contact you throughout the duration of your case and for up to a year and a half after your case closes. It is important that you respond to these contacts and provide the requested documentation.

_____ It is my responsibility to inform my counselor of any changes related to this application, such as changes in my address, income or employment.

_____ I will not be discriminated against by Rehabilitation Services because of disability, age, race, color, ethnicity, natural origin, gender/ sex, gender identity, sexual orientation, religion, or political affiliation or belief.

_____ There is no cost for services provided directly to me by VR staff. I will be asked to furnish financial information and my financial needs will be taken into consideration when determining my participation in the costs of services that VR must purchase from another entity.

_____ If VR pays for goods or services for which I am financially responsible, I agree to reimburse VR the portion of the costs for which I am responsible.

_____ I agree to provide accurate financial information and abide by the following conditions:

- □ All goods and services funded by VR are intended to assist me to complete IPE (Individualized Plan for Employment) objectives so that I can obtain and maintain employment. I agree to be honest regarding my vocational needs when requesting funding for goods and services, and to use the goods and services purchased by VR in a responsible manner for the purposes intended.

- □ I will not use, or allow others to use, goods and services purchased by VR on my behalf in a manner that would make them unavailable for VR services or that would compromise my ability to use them in the manner intended.

- □ I will abide by and be held accountable for all policies related to the use of VR funds on my behalf.
- □ I will provide all documentation required by VR. For example, receipts, mileage logs, grades reports, signed acknowledgements of receipt of goods and services (RD-87s) etc.

VR will not pay for or reimburse me for any service for which my counselor has not issued a written authorization for purchase (note: verbal agreement to provide a service or inclusion of a service on my individualized plan for employment does not constitute a written authorization for purchase).

VR may recover funds for items purchased without authorization or agency approval and VR funds spent on items for which I was financially responsible. Inappropriate use of goods or services funded by VR or **failure to provide required documentation**; such as mileage logs, RD-87s, receipts may result in suspension of services, a requirement to reimburse VR for the goods or services, return of the goods and/or case closure. If funds are still owed to VR from a previous case, new services may be suspended until VR is reimbursed. Knowingly and deliberately withholding, concealing or misrepresenting information to obtain or attempt to obtain VR services or funding may be fraud. Serious cases of fraud or intent to commit fraud may result in immediate case closure and/or a report to law enforcement may be filed seeking criminal prosecution.

Applicant Signature _____

Date of Signature _____

Parent / Guardian / Legal Rep Signature _____

Date of Signature _____

Signature of Individual Who Filled Out Application if Different From Above

_____

Date of Signature _____

Parent / Guardian / Legal Rep Address _____

_____

Email Address _____

Telephone _____