

**OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
VOCATIONAL REHABILITATION AND VISUAL SERVICES APPLICATION**

Name _____ SSN _____

Home Phone Number _____ Cell Phone Number _____

Home Address _____ City, State, Zip _____

Email Address _____

What is your disability?

Onset of Disability _____ Male Female Date of Birth: _____

Describe how your disability impairs your ability to work (or to live independently)?

I am interested in assistance in obtaining employment

I am interested in assistance in keeping the job I have

For individuals age 55 or older who are blind or visually impaired please check your preference:

I am not interested in working, however I am interested in assistance in living independently

What type of employment are you interested in, and how can we help you achieve your goal?

Have you ever applied for rehabilitation services? yes when? _____ no

Do you receive SSI or SSDI Benefits? yes no

Have you ever been convicted of a felony? yes no

Have you ever defaulted on a student loan? yes no

My completion of this document constitutes an application for Rehabilitation Services. In order to effect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. All information both medical and personal given or made available to the agency shall be held to be confidential. Use of such information will be limited to purposes directly connected with the administration of my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended; Title 56, Oklahoma Statute 1971, sections 328 through 330 and Title 51 Oklahoma Statute 1985, Section 24A.1 through 24A.18. Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Otherwise, information will not be disclosed to any individual, agency or organizations without my written consent or that of my parent, guardian or representative as applicable.

I attest under penalty of perjury that I am (check one of the following)

A Citizen or national of the U.S. A Lawful Permanent Resident An Alien authorized to work

Information provided is subject to verification through the Social Security Administration.

Client _____ Date _____

Parent/Guardian/ _____ Date _____

Representative _____ Date _____

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
(56 O.S. § 71)

Statement Under Penalty of Perjury
(12 O.S. § 426)

I _____ (D.O.B.) _____ , hereby state as follows:
(Applicant)

I am a United States Citizen.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

Date

County

[Signature of Applicant]



I _____ (D.O.B.) _____ , hereby state as follows:
(Applicant)

I am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

Date

County

[Signature of Applicant]

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
CLIENT INFORMATION FORM

SSN _____

Last Name _____ First Name _____ Middle Initial _____

Home Address _____
(Street, Route, P.O. Box #, etc.)

City: _____ State: _____ Zip: _____

County: _____

Do you live in a private residence? yes no

If No, Please Describe: _____

Mailing Address if different from above: _____

Directions to Home: _____

RACE & ETHNICITY:
*If Hispanic or Latino check more than one.
Ex: Hispanic & American Indian*

<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or other Pacific Islander

Please indicate below if you require an alternate correspondence format:

Audio Tape Braille Large Print Other _____

If you will you require any other accommodations, please describe. _____

Marital Status: divorced married never married separated widowed

Who referred you to us? _____

List three people whom we may contact in an attempt to locate you, should your current contact information become outdated.

1. Last Name: _____ First Name: _____
 Relationship: _____ Address/City _____
 Home phone: _____ Cell or work phone: _____
 E-Mail address: _____

2. Last Name: _____ First Name: _____
 Relationship: _____ Address/City _____
 Home phone: _____ Cell or work phone: _____
 E-Mail address: _____

3. Last Name: _____ First Name: _____
 Relationship: _____ Address/City _____
 Home phone: _____ Cell or work phone: _____
 E-Mail address: _____

Number of family living in your household: _____

LIST ALL HOUSEHOLD MEMBERS WITH INCOME INFORMATION
 (Include Wages, SSI, SSDI, TANF, Worker's Comp., Unemployment, etc.)

Name	Relationship	Source of Income	Monthly Amount
	Self		

Please check if you have:

- Medicare
 Medicaid
 Private Insurance through own employment
 Private Insurance through other means
 Public insurance from other sources
 None

Primary Insurance Carrier _____
 Policy Number _____
 Medicaid Number _____ Medicare Number _____

Level of Education attained at time of this application: _____

Have you received services under an Individualized Education Program (IEP)? yes no

<i>High School</i>	<i>City and State</i>	<i>Highest Grade Completed</i>	<i>Dates Attended</i>	<i>Area of Study</i>	<i>Graduated?</i>	<i>Hours, Degree, or Certificate Earned</i>
					<input type="checkbox"/> yes <input type="checkbox"/> no	
<i>College (Most Recent)</i>						
					<input type="checkbox"/> yes <input type="checkbox"/> no	
<i>Technical</i>					<input type="checkbox"/> yes <input type="checkbox"/> no	
<i>Other Training</i>					<input type="checkbox"/> yes <input type="checkbox"/> no	

List Your Last Three Jobs

<i>Job Title</i>	<i>Employer Name</i>	<i>Employer Address</i>	<i>Weekly Hours and Salary</i>	<i>Dates of Employment</i>	<i>Reason for Leaving</i>	<i>Disability-Related Problems Affecting Job</i>
Most Recent Job 1.						
2.						
3.						
Other Work Experience						

Are you a Veteran?

yes no

Are you currently receiving services from an American Indian Tribal VR Program?

yes no

Are you currently receiving services from Hissom?

yes no