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/
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

☐ White ☐ Black or African American ☐ Hispanic or Latino

☐ American Indian or Alaska Native ☐ Asian ☐ 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

High School	***City and State***	***Highest Grade Completed***	***Dates Attended***	***Area of Study***	***Graduated?***	***Hours, Degree, or Certificate Earned***
					☐ yes ☐ no	
College (Most Recent)						
					☐ yes ☐ no	
Technical					☐ yes ☐ no	
Other Training					☐ yes ☐ no	

List Your Last Three Jobs

Job Title	*Employer Name*	*Employer Address*	*Weekly Hours and Salary*	*Dates of Employment*	*Reason for Leaving*	*Disability-Related Problems Affecting Job*
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