How to apply -

Applying for VR services requires a series of steps:

1. An individual provides information to VR staff during an intake interview. Information requested by IDVR is necessary to begin the eligibility assessment process.

   AND

2. An individual agrees that he or she is available to complete the assessment process required to determine eligibility for VR services.

   AND

3. At the intake interview, the individual provides a signed and dated application signature sheet to IDVR or makes an alternative request for application to IDVR.

The application process is complete when all steps have occurred.

It is helpful to complete the attached intake form and provide it to VR at your first appointment. However, you are not required to complete an intake form to schedule an appointment or meet with a VR counselor.

Contact your local VR office if you have additional questions about eligibility requirements, the application process, or would like to apply for services.

We look forward to working with you!

_Idaho Division of Vocational Rehabilitation_
I am a previous VR Customer:  □ Yes  □ No
If Yes, Where? ______________________________________

MY PERSONAL INFORMATION:

SS#: _____-____-____

Last Name: ___________________________  First Name: ___________________________

Middle: ___________________________  Preferred Name: ___________________________

Birth Date: _____/_____/_____  

Gender:  □ Male  □ Female  □ Do not wish to Gender Identify

Previous Last Name: ____________________

MY ADDRESS:

Home Address:

City: ___________________________  State: ___________________________  Zip: __________

County: ___________________________

☐ Check if mailing address is the same as home address

Mailing Address:

City: ___________________________  State: ___________________________  Zip: __________

County: ___________________________

Primary Phone: (____)-____-_____  □ Voice  □ VP  □ Fax

Second Phone: (____)-____-_____  □ Voice  □ VP  □ Fax

E-mail: ___________________________
ETHNIC (must check one):
☐ Hispanic/Latino
☐ Not Hispanic/Latino

RACE: (must check at least one or more than one):
☐ American Indian or Alaska Native (tribal affiliation):
☐ Asian
☐ Black/African-American
☐ Does Not Wish to Self-Identify (adults only)
☐ Native Hawaiian or other Pacific Islander
☐ White

Are you legally able to work in the United States? ☐ Yes ☐ No

Are you your own legal guardian? ☐ Yes ☐ No

Legal guardian’s name: ___________________________ ☐ Voice ☐ VP ☐ Fax

Guardian’s phone: ______-_____-____

CONTACTS: (Examples: Family, Friends, PO, Case Worker Etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
<th>Ext.#</th>
<th>Voice/VP/Fax</th>
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What are your current living arrangements?
☐ Private Residence (home, apt, live w/family
☐ Mental Health Facility
☐ Adult Correction Facility
☐ Nursing Home
☐ Community Residential/group home
☐ Other
☐ Halfway House
☐ Rehabilitation Facility
☐ Homeless/Shelter
☐ Substance Abuse Treatment Center

Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed

Who referred you to VR? ____________________________________________

FINANCIAL:
Including yourself, number in household: _____ Number of Dependents: _____
Primary source of income/financial support:

- [] Personal Income (Employment earnings, interest, dividends, rent, retirement, and/or Social Security retirement benefits)
- [] Family and Friends
- [] Public Support (SSI, SSDI, TANF, etc.)
- [] All Other Sources (e.g., private disability insurance, private charities, child support etc.)

SSDI Status: [ ] allowed [ ] denied [ ] pending [ ] not an applicant

SSI Status: [ ] allowed [ ] denied [ ] pending [ ] not an applicant

SSDI Aged: $_____ VA: $_____ Workers Comp: $_____  
SSI Disabled: $_____ TANF: $_____ Unemployment Ins. $_____  
SSD: $_____ TANF end date: _____ Other Public Support: $_____

I have one or more of the following medical insurances:

- [] Medicaid
- [] Medicare
- [] None
- [] Private insurance (Employer Pending)
- [] Private insurance through other means
- [] Private insurance through own employer
- [] Public insurance from other sources
- [] State or Federal Affordable Care Act Exchange

EMPLOYMENT:
I am requesting VR Services to Maintain Current Employment [ ] Yes [ ] No

My Work History:
(Starting with most recent and include applicable volunteer work)

#1 Employer: ____________________________
Job Title: ____________________________
Job Duties: ____________________________
Weekly hours worked: _____ Hourly wage: _____ Start date: _____ End date: _____
Reason for leaving: ____________________________
How did you get this job: ____________________________
What duties did your disability make more difficult to perform: ____________________________
Was a special license required (CNA, CDL, etc.): ____________________________
Can you return to this job?  □ Yes  □ No
If not, why: ____________________________________________

Could someone at this employment give you a reference? □ Yes  □ No
Who? ___________________________________________________

#2 Employer: _____________________________________________
Job Title: ________________________________________________
Job Duties: ______________________________________________

Weekly hours worked: _____  Hourly wage: _____  Start date: _____  End date: _____
Reason for leaving: ______________________________________

How did you get this job: __________________________________

What duties did your disability make more difficult to perform: __________________________

Was a special license required (CNA, CDL, etc.):

Can you return to this job?  □ Yes  □ No
If not, why: ____________________________________________

Could someone at this employment give you a reference? □ Yes  □ No
Who? ___________________________________________________

#3 Employer: _____________________________________________
Job Title: ________________________________________________
Job Duties: ______________________________________________

Weekly hours worked: _____  Hourly wage: _____  Start date: _____  End date: _____
Reason for leaving: ______________________________________

How did you get this job: __________________________________

What duties did your disability make more difficult to perform: __________________________
Was a special license required (CNA, CDL, etc.):

________________________________________

Can you return to this job? □ Yes □ No
If not, why: __________________________________________________________

________________________________________

Could someone at this employment give you a reference? □ Yes □ No
Who? ________________________________________________________________

#4 Employer: __________________________________________________________
Job Title: ____________________________________________________________
Job Duties: __________________________________________________________

Weekly hours worked: _____ Hourly wage: _____ Start date: _____ End date: _____
Reason for leaving: ____________________________________________________

________________________________________

How did you get this job: ______________________________________________

________________________________________

What duties did your disability make more difficult to perform: ______________

Was a special license required (CNA, CDL, etc.):

________________________________________

Can you return to this job? □ Yes □ No
If not, why: __________________________________________________________

________________________________________

Could someone at this employment give you a reference? □ Yes □ No
Who? ________________________________________________________________

#5 Employer: __________________________________________________________
Job Title: ____________________________________________________________
Job Duties: __________________________________________________________

Weekly hours worked: _____ Hourly wage: _____ Start date: _____ End date: _____
Reason for leaving: ____________________________________________________

________________________________________

How did you get this job: ______________________________________________
What duties did your disability make more difficult to perform: ____________________________________________

Was a special license required (CNA, CDL, etc.):
_____________________________________________________________________________________

Can you return to this job?  ☐ Yes  ☐ No
If not, why: _________________________________________________________________________

Could someone at this employment give you a reference?  ☐ Yes  ☐ No
Who? ______________________________________________________________________________

Veteran:  ☐ Yes  ☐ No

DISABILITIES:
Please describe your disabilities and functional limitations: (Physical, Injuries, Mental Health, Depression, Substance Abuse, drug and/or alcohol, Learning Disability, etc.)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

My disability makes it difficult to? (Describe how it affects you in the space provided)
☐ Stand  ☐ Walk  ☐ Sit  ☐ Lift  ☐ Bend  ☐ Use hands or feet
Explain:
____________________________________________________________________________________
____________________________________________________________________________________

☐ See  ☐ Hear  ☐ Read  ☐ Write
Explain:
____________________________________________________________________________________
____________________________________________________________________________________

☐ Concentrate  ☐ Remember  ☐ Learn  ☐ Understand
Explain:
____________________________________________________________________________________
____________________________________________________________________________________

☐ Handle stress  ☐ Control emotions  ☐ Work with others  ☐ Communicate
Explain:
____________________________________________________________________________________
____________________________________________________________________________________

☐ Other:
Explain:
____________________________________________________________________________________
____________________________________________________________________________________

Revision Update 07-01-2017
How do your disabilities affect your current ability to work or keep a job?

________________________________________________________________________

How do you think Vocational Rehabilitation can help you get a job and keep one?

________________________________________________________________________

What are your employment needs?

________________________________________________________________________

ARE YOU RECEIVING SERVICES OR FUNDING FROM ANY OF THESE PROGRAMS?

☐ Adult Education and Literacy Program (AE) Date Started: ___/___/___
☐ Adult Program (Department of Labor) Date Started: ___/___/___
☐ Dislocated Worker (Department of Labor) Date Started: ___/___/___
☐ Employment Services (Department of Labor) Date Started: ___/___/___
☐ Job Corps Date Started: ___/___/___
☐ Youth (Department of Labor) Date Started: ___/___/___
☐ YouthBuild Date Started: ___/___/___
☐ None

Foster Care: ☐ Yes; is currently in foster care or was previously in foster care. ☐ No; have never been in foster care.

Single Parent: ☐ Yes  ☐ No ☐ Does not wish to self-identify
(Currently a single parent with a dependent child under 18 or is pregnant)

Displaced Homemaker ☐ Yes  ☐ No (was providing services to family member(s) while dependent upon another family member’s income or due to military service of a spouse)

Migrant or Seasonal Farmworker: ☐ Yes  ☐ No
☐ Low income, primarily employed for last 12 to 24 months in farming labor
☐ Is a seasonal farmworker and distance to job site does not allow for daily return to permanent home
☐ Is a Dependent of migrant/seasonal farmworker
Do you have a driver's license? ☐Yes ☐No
Do you drive/mode of transportation? ________________________________
Do you require communication assistance? ☐Yes ☐No
Explain: _________________________________________________________
Other needs request: _____________________________________________

HIGHEST LEVEL OF EDUCATION AT REFERRAL (please check one)

☐ No Formal Education
☐ Elementary Education
  (circle grade) 1 2 3 4 5 6 7 8
☐ Secondary Education - no HS diploma
  (circle grade) 9 10 11 12
☐ 12th Grade (18-21 services)
☐ High school diploma
☐ GED
☐ Adult Secondary Education (AE-GED)
☐ Postsecondary (1st-4th Year) __________

Completion Date (month/year) for Highest Level of
Education checked above: __________________________

If I am attending school, the name of the school is: ________________________________
If I am attending school, I am currently in what year/grade: __________________________
(H.S. 9th, 10th, 11th, 12th, 12th/18-21; GED, AE, Career/Tech-Credited/Non, Postsecondary: 1st, 2nd, 3rd, 4th year; Higher than Bachelor’s)
I am a student with a disability in high school: ☐Yes ☐No
I have a current 504 Accommodation Plan: ☐Yes ☐No
I have a current IEP: ☐Yes ☐No
What month/year did you start high school: _____________
What month/year did/will you graduate: _____________
Graduation date for highest level of education: ___________
Have you been convicted of a felony or a misdemeanor:  □ Yes  □ No
Offense(s):
_____________________________________________________________________________________

Date of Conviction(s):  ________________________________________________________________
State Where Conviction(s) occurred:  ______________________________
Probation/Parole officer is:  ____________________________________________________________
IDOC #  ______________________________
Date Probation Started:  ______________________________
Completion Date  ______________________________
Restitution owed  ______________________________

******Agency Use Only******

Next step in establishing eligibility:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Counselor additional information or comments:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Revision Update 07-01-2017