



Participant Information/Application for Vocational Rehabilitation Services

PLEASE PRINT

Name (Last)		First	M.I.	Suffix (e.g., Jr.)	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date (mm/dd/yyyy)		County of Residence	
Home Address (Street)			City	State	Zip Code
Home Phone No.	Alternate Phone #	E-mail Address			
Race/ethnicity: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White			
Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please list your immigration status:					
Contact person(s): If you complete this section, you are permitting OOD to disclose to the individual that you have applied for services.					
Name		Address (Street, City, State, Zip)			Phone No.
Where do you live? <input type="checkbox"/> Assisted Living Center <input type="checkbox"/> Community Residential/Group Home <input type="checkbox"/> Correctional Institution, Adult		<input type="checkbox"/> Dependent with Family or Friends <input type="checkbox"/> Halfway House <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Independent <input type="checkbox"/> Mental Health Facility <input type="checkbox"/> Not Available		<input type="checkbox"/> Nursing Home <input type="checkbox"/> Private Residence <input type="checkbox"/> Rehabilitation Facility <input type="checkbox"/> Substance Abuse Treatment Ctr <input type="checkbox"/> Other (Indicate)	
Would you like to register to vote? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already registered <input type="checkbox"/> Not Eligible					

Are you referring yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who is referral source?	
How do you financially support yourself? <input type="checkbox"/> Personal income <input type="checkbox"/> Family and friends <input type="checkbox"/> Public support (Click all that apply): <input type="checkbox"/> SSI, <input type="checkbox"/> SSDI, <input type="checkbox"/> TANF, <input type="checkbox"/> Food stamps <input type="checkbox"/> Other sources, List:	Which types of medical insurance do you receive? Click all that apply. <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Public through Other Sources <input type="checkbox"/> Private Ins, through Own Employment <input type="checkbox"/> Private Ins, through Other Means <input type="checkbox"/> None <input type="checkbox"/> Not Available
What is your highest grade completed? <input type="checkbox"/> No formal Schooling <input type="checkbox"/> Elementary education (1-8) <input type="checkbox"/> Secondary education (9-12), No High School Diploma <input type="checkbox"/> Special Ed.(completion or attendance)	<input type="checkbox"/> High school graduate or equivalency (Reg GED) <input type="checkbox"/> Post-secondary education, No degree <input type="checkbox"/> Associate degree or voc/tech cert <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree or higher
Have you ever received services under an individualized education plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your hourly wage? How many hours per week?	
Are you currently enrolled in high school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your disability?	
<p>This application will be considered complete when it is initialed and dated by VR Staff or VR Contractor at the time of your appointment.</p> <p>The State of Ohio is committed to good privacy practices. As such, we are disclosing that in order to fully process your application, verify your eligibility and provide vocational rehabilitation services, the Opportunities for Ohioans with Disabilities (OOD) may need to access personal information about you, such as your Social Security Number, which is maintained by the OOD. By signing this application, you are requesting that OOD access any personal information necessary to process your application, determine eligibility and provide services. Please note that OOD will continue to protect any non-public, confidential personal information maintained about you from release to the</p>	

public or unauthorized third parties.

OOD does not discriminate against any applicant for services on the basis of race, color, religion, national origin/ancestry, disability, age, veteran or military status, and/or genetic information or in any manner prohibited by law.

I acknowledge that in applying for services, OOD may obtain or release confidential personal information about me as follows:

- to purchase services for me;
- in collaboration with OOD Contractors and Partners on my behalf;
- to report my progress to the agency who referred me to OOD;
- when required by law and to facilitate the administration of the Rehabilitation Act;
- to do research to improve the lives of people with disabilities;
- to the Social Security Administration (SSA) and/or Division of Disability Determination (DDD) when I am applying for or am a recipient of SSDI or SSI benefits; and
- to other state agencies, if applicable.

Signature of Applicant (If under 18, parent/guardian must also sign below)

Date

Signature of Parent or Guardian

Date

OOD Use Only: I have explained OOD services and procedures, the applicant's rights, confidentiality, the Client Assistance Program (CAP), and the right to register to vote. I have provided the applicant the Application Fact Sheet about rights, duties and informed choice. I have also provided a copy of this application in the preferred mode of communication of this applicant. I certify that this application is accurate.

Initials

Date

How was this form received? Electronically In Person Mail
 Phone Other:

Original – Counselor

Copy – Applicant