OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND AND VISUALLY IMPAIRED APPLICATION

Name: Last _____

First _____ Middle _____

SSN _____ Date of Birth _____ Male Female Decline to identify

Preferred Name _____ Other Last Name(s) _____

Address _____

City _____ State _____ Zip _____ County _____

Mailing Address (if different) _____

Home Phone Number _____ Cell Phone Number _____

Email Address _____

Directions to Home _____

Race & Ethnicity

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

White | Hispanic or Latino | Asian | Decline to identify

Black or African American | American Indian or Alaska Native | Native Hawaiian or other Pacific Islander

My primary language is _____

Do you need an interpreter? Yes No If yes, please specify _____

Please indicate below if you prefer an alternate correspondence format:

Email Braille Large Print Other _____

If you need any other accommodations, please describe

Do you have a legal representative? Yes No If yes, please specify _____

List three people whom we may contact in an attempt to locate you, should your current contact information become outdated.

Last Name: _____ First Name: _____

Relationship: _____ Address/City _____

Home phone: _____ Cell or work phone: _____

E-Mail address: _____

Last Name: _____ First Name: _____

Relationship: _____ Address/City _____

Home phone: _____ Cell or work phone: _____

E-Mail address: _____

Last Name: _____ First Name: _____

Relationship: _____ Address/City _____

Home phone: _____ Cell or work phone: _____

E-Mail address: _____

Living arrangement:

Private Residence	Rehabilitation Facility
Halfway House	Community Residential/Group Home
Correctional Institution - Juvenile	Substance Abuse Treatment Center
Mental Health Facility	Correctional Institution - Adult
Nursing Home	Homeless / Shelter

Marital Status:

Divorced Married Never married Separated Widowed

Citizenship Status:

Citizen or national of the U.S.

Alien authorized to work (Must copy card & refer to **SAVE** program)

Please print card _____

Lawful Permanent Resident (Must copy card & refer to **SAVE** program)

Please print card _____

Are you currently enrolled in school? Yes No

Who referred you to our agency? _____

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

Number of family living in your household

Name	Relationship	Source of Income	Monthly Amount
	Self		

Do you receive SSI and/or SSDI benefits? Yes No

Please check all insurance/medical coverage you have:

Medicare Medicare Number _____ Effective Date _____

Medicaid Medicaid Number _____ Effective Date _____

Indian Health Services Private Insurance Veterans Administration

Other Public Insuranc None

Carrier/Policy number/Effective date	Policy holder

STAFF NOTES

LIST YOUR LAST THREE JOBS:

Do you need help to maintain your current employment? Yes No

1. _____
   Current Employer Name & Address Current Job Title Hours per week

   _____
   Weekly Salary Dates Employed (MM/YY) – Present Disability related problems affecting job

2. _____
   Previous Employer Name & Address Previous Job Title Hours per week

   _____
   Weekly Salary Dates Employed (MM/YY) – (MM/YY) Disability related problems affecting job
   Reason for leaving: _____

3. _____
   Previous Employer Name & Address Previous Job Title Hours per week

   _____
   Weekly Salary Dates Employed (MM/YY) – (MM/YY) Disability related problems affecting job
   Reason for leaving: _____

What are some jobs you are interested in pursuing? _____

_____

Are you a Veteran? Yes No

Have you ever applied for rehabilitation services in the past? Yes, When? _____ No

Are you receiving services from a Tribal VR program? Yes No

Are you receiving services from Developmental Disabilities Services (DDS)? Yes No

Are you currently receiving services or funding from any other agencies? Yes No

If yes, please list all: _____

Do you have a student loan in default status? Yes No

Do you want to register to vote? Yes No

Do you have a felony conviction? Yes No

Do you have transportation available to you? Yes No

What do you need in order to gain or maintain employment? _____

_____

Have you ever received services under an Individualized Education Program IEP? Yes No

Have you ever received services under a 504 plan? Yes No

LIST YOUR EDUCATION HISTORY:

High School

_____
School Name City/State

_____
Grade Completed Begin Date Graduation/Expected Graduation Date

College

School name | City/State

Hours Completed or Degree Earned | Major | Begin Date | Graduation/Expected Graduation Date

Technical

School Name | City/State

Grade/Certificate Completed | Area of Study | Begin Date | Graduation/Expected Graduation Date

Other

School Name | City/State

Grade/Hours Completed | Area of Study | Begin Date | Graduation/Expected Graduation Date

Disability information:

Describe your disability _____

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

Non-Visual Impairments/Conditions that hinder or keep you from working:

- Hearing Impairment
- Learning Disability
- Cognitive Impairment
- Diabetes Mellitus
- Orthopedic
- Respiratory/Lung Condition Cancer
- Substance Abuse Issue(s)
- Mental Health Disorder
- Autism Spectrum Disorder
- Neurological Disorder
- Kidney Disorder
- Amputation
- Cardiac/Circulatory
- Other _____

Visual Impairment/Conditions:

- Totally Blind
- Legally Blind
- Severe Visual Impairment

Major Cause of Visual Impairment:

- Macular Degeneration
- Diabetic Retinopathy
- Glaucoma
- Cataracts
- Other _____

Name and address of your personal physician(s) or clinic where you have been treated: _____

_____

Are you currently receiving treatment for any of these conditions? Yes No

If yes, Condition	Dr. Name & Address	Phone Number	Dates Seen

Have you been hospitalized for any of these conditions in the past two years? Yes No
If yes, list the condition(s) and the name of the hospital(s) _____

_____

Are you currently taking medication as a result of a disability? Yes No

If yes, Condition	Medication	Condition	Medication

STAFF NOTES

Written Notice of Beneficiary Protections

Because this program is supported in whole or in part by financial assistance from the U.S. Department of Education, we are required to provide you the following information: (1) We may not discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to attend or participate in a religious practice; (2) We may not require you to attend or participate in any explicitly religious activities (including activities that involve overt religious content such as worship, religious instruction, or proselytization) that may be offered by our organization, and any participation by you in such activities must be purely voluntary; (3) We must separate in time or location any privately funded explicitly religious activities (including activities that involve overt religious content such as worship, religious instruction, or proselytization) from activities supported with direct Federal financial assistance; (4) You may report violations of these protections, including any denials of services or benefits by an organization, by contacting or filing a written complaint with the U.S. Department of Education at 877-292-3804.

My completion of this document and the completion of the initial interview process with DRS staff 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 federal Rehabilitation Act of 1973, as amended (29 U.S.C. § 701 et seq.); Title 74 of the Oklahoma Statutes, Sections 166.1 through 166.12; and Title 51 of the Oklahoma Statutes, Sections 24A.1 through 24A.33. 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.

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

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]

OR

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

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]

STAFF ONLY

If not a U.S. Citizen, a referral must be made to SAVE. Date referred _____