State of Rhode Island
Department of Human Services
Office of Rehabilitation Services
40 Fountain Street ~ Providence, RI 02903
401-421-7005 ~ 401-222-3574 FAX ~ RI Relay – 711 ~ Spanish 401-462-7791
www.ors.ri.gov
"Helping individuals with disabilities to choose, find and keep employment"

ORS Use
Region:
Area:

Application and Initial Information for the Vocational Rehabilitation (VR) Program

Please fill out this application to the best of your ability. If you do not feel comfortable disclosing some of the information, you can complete the application when you meet with an Office of Rehabilitation Services (ORS) Counselor.

Legal Name: _____ Preferred Name (if different): _____

Street Address: _____ City/State/Zip code: _____

Phone Number: _____ Cell/Video Relay: _____

Date of Birth (mm/dd/yyyy): _____ Email address: _____

Gender Identity: _____ Preferred Pronouns: _____

Social Security Number: _____ Emergency Contact: _____

Are you a Veteran: ☐ Yes ☐ No Have you previously applied for VR services: ☐ Yes ☐ No

If yes, provide previous name on prior application: _____

What is your disability: _____

What is your employment or career goal(s): _____

How did you learn about VR and who referred you: _____

Do you receive: ☐ SSDI ☐ SSI (Attach award letter, if available) Did you receive a Ticket to Work: ☐ Yes ☐No

Do you have a drivers license: ☐ Yes ☐ No What transportation is available to you: ☐ Car ☐ Bus ☐ Other

Is your drivers license active: ☐ Yes ☐ No What state issued your drivers license: _____

What type of license do you have (CDL, learners permit, restricted): _____

If your license is restricted, please describe why: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race (Check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native

Do you speak English: ☐ Yes ☐ No If no, what is the primary language spoken: _____

Have you currently been unemployed for more than 27 consecutive weeks: ☐ Yes ☐ No

Do you want to register to vote: ☐ Yes ☐ No

Have you ever been convicted of a felony: ☐ Yes ☐ No

I am applying for Vocational Rehabilitation services because I want to work or obtain employment.

Applicant signature: _____ Date (mm/dd/yyyy): _____

Parent/Guardian (if applicable): _____ Date (mm/dd/yyyy): _____

Counselor receipt of application (ORS Personnel Only): _____

Your assistance in providing the information requested on the following pages will help speed up your eligibility and employment plan process. A Vocational Rehabilitation Representative can assist you in completing the information if you wish. Please contact (401) 421-7005 (Intake) or RI Relay at 711 if you need assistance to complete the form. En Espanol, (401) 462-7791.

Work History

Employer name and address: _____

How did you get this job: _____

Hours per week: _____ Date of employment (mm/dd/yyyy):_____ to _____ Hourly pay: _____

Job title/skills: _____

Most liked about job: _____

Least liked about job: _____

Reason for leaving job: _____

Education

High School: _____ Highest grade complete: _____

Diploma received: ☐ Yes ☐ No Date received: _____

Special Education Certification of Completion: ☐ Yes ☐ No

GED: ☐ Yes ☐ No Date received: _____

Special Education (IEP/504): ☐ Yes ☐ No

Support services provided (example: technology, aide, etc.):

College: _____ Years attended: _____

Degree obtained: _____

Other skills/training: _____

Certification(s) obtained: _____

Date of certifications (mm/dd/yyyy): _____

Disability / Medical Condition (What prevents you from working)

Describe your limitations regarding employment:

Technology / Supports / Resources needed to work:

Physicians / Hospital / Mental Health / Psychologist / Social Worker

Physicians/Hospital/Clinic	Specialty	Dates of Service

Medications / Treatments	Name / Type	Dosage / Frequency

Medical Coverage

Provider	Claim Number	Provided by Employer

Medicaid: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No Private: ☐ Yes ☐ No Other: ☐ Yes ☐ No

Public Benefits / Income

I. Gross Income

Category	Comment	Amount (Wk. / Mo. / Yr)
Wages / Salary		$
Supplemental Security Income (SSI)		$
Social Security Disability Insurance (SSDI)		$
Family Independence Program (FID) / RI Works		$
Temporary Disability Insurance (TDI)		$
Workers Compensation		$
Veterans Benefits		$
Unemployment Benefits		$
Private Disability Insurance		$
Pension or Annuity		$
Other Income		$

(Savings, including spousal income, rent, interest, etc.)

II. Rehabilitation Expenses (Non-Reimbursable)

Category	Comment	Amount (Wk. / Mo. / Yr)
Medical		$
Rehabilitation / Adaptive Technology		$
Other Rehabilitation Needs		$
Cash, Savings, and Other Liquid Assets		$

Certification:

(Complete once you have met with a VR Representative)

I have been provided with an explanation of the VR program, my rights and responsibilities, and I have been given a Client Assistance Program (CAP) brochure. I have been informed that I can appeal decisions, and I have been told how to do this. I have also been advised of the necessity to have all services pre-approved by my ORS Representative and to keep him/her informed of any changes in my situation whether medical, financial, or otherwise. I certify that the information I give is true and complete to the best of my knowledge and belief, and I know that false or misleading statements or failure to report changes may result in prosecution for intent to defraud. I understand that the information given is confidential, and it will be used only for purposes directly connected with the administration of the VR program.

I agree to notify my ORS Counselor when I become employed and allow ORS to access my wage records.

Signature of Applicant: _____ Date (mm/dd/yyyy): _____

Parent / Guardian (if applicable): _____ Date (mm/dd/yyyy): _____

Person who assisted with application: _____ Phone number: _____

Signature of Vocational Rehabilitation Counselor: _____

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Current Health and Functional Capacities Self – Assessment

Category	Average	Some Problems	Comments
Using Transportation	☐	☐	
Walking	☐	☐	
Climbing	☐	☐	
Hearing	☐	☐	
Speaking/Conversing	☐	☐	
Reading	☐	☐	
Writing	☐	☐	
Mood/Attitude	☐	☐	
Stress	☐	☐	
Getting Along with Others	☐	☐	
Concentration	☐	☐	
Remembering	☐	☐	
Daily Life Routine	☐	☐	
Taking Medication	☐	☐	
Impulsivity	☐	☐	
Making Decisions	☐	☐	
Learning New Tasks	☐	☐	
Planning/Setting Goals	☐	☐	
Accepting Direction	☐	☐	
Punctuality	☐	☐	
Getting/Keeping a Job	☐	☐	
Sitting/Standing	☐	☐	
Bending	☐	☐	
Lifting/Pushing/Pulling	☐	☐	
Gripping/Holding Feeling	☐	☐	
Balance/Coordination	☐	☐	
Fatigue/Stamina	☐	☐	
Breathing/Allergies	☐	☐	
Vision	☐	☐	

Do you have any other barriers to employment that are not listed above: _____

Have you been hospitalized in the past two years: ☐ Yes ☐ No

Do you use: ☐ Tobacco ☐ Alcohol ☐ Drugs If yes, how much: _____

Do you have a history of dependency on: ☐ Alcohol ☐ Drugs Sobriety date: _____

If planning for work, are you concerned with the loss of SSI / SSDI benefits: ☐ Yes ☐ No

This is the best estimate of my abilities and limitations.

Signature of Applicant: _____ Date (mm/dd/yyyy): _____