



State of Delaware | Department of Labor
 Division of Vocational Rehabilitation
Application for DVR Employment Services
 This is a confidential communication

FOR OFFICE USE ONLY

Intake Date: _____

Counselor: _____

Participant #: _____

The Division of Vocational Rehabilitation's (DVR) main focus is to partner with people with disabilities who are seeking employment and help them develop a career pathway to find long term, meaningful employment. Please complete all fields of this application. Thank you for your help.

Last Name:		First Name:		MI:
Preferred/Nickname:			Previous Last Name:	
Physical Address:				
City:	State:	Zip Code:	County:	
Mailing Address (if different from Physical Address):				
City:	State:	Zip Code:	County:	
Telephone Number:	Cell Phone Number:		Alternate Phone Number:	
Email Address:				
Social Security Number:			Date of Birth:	

What are your disabilities?

How do your disabilities affect your ability to work?

Race (Check all that apply): <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian Or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander	Ethnicity: Are you Hispanic/Latino? <input type="radio"/> Yes <input type="radio"/> No Gender: <input type="radio"/> Female <input type="radio"/> Male	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed	Are you a U.S. Citizen? <input type="radio"/> Yes <input type="radio"/> No If you answered no, are you legally able to work in the U.S.? <input type="radio"/> Yes <input type="radio"/> No Are you a veteran? <input type="radio"/> Yes <input type="radio"/> No
--	---	---	--

Emergency Contact (Someone who will know how to contact you):			
Name:		Relationship to you:	
Primary Phone:		Secondary Phone (Cell):	
Physical Address:			
City:	State:	Zip Code:	County:

What are your current living arrangements? <input type="checkbox"/> Private Residence (Independent, Family, etc.) <input type="checkbox"/> Substance Abuse Treatment Facility <input type="checkbox"/> Community/Group Home <input type="checkbox"/> Adult Correctional Facility <input type="checkbox"/> Halfway House <input type="checkbox"/> Rehabilitation Facility <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other: _____	Who provides most of the money you need to support yourself? <input type="checkbox"/> Own personal income <input type="checkbox"/> Public Support (SSI, SSDI, TANF, etc.) <input type="checkbox"/> Family/Friends <input type="checkbox"/> Other If Other: _____ <hr/> Number of Dependents: _____ Gross Monthly Family Income: _____
--	---

How much money do you receive from these sources per month?		
SSI _____	SSDI _____	SSA Retirement benefits _____
TANF _____	VA Disability _____	Other Public Support _____
General Assistance _____	Worker's Compensation _____	If Other Support: _____

Do you have medical insurance? Please check all that apply.						
Yes	No	Medicaid	Medicare	Public, via other sources	Private, via my employer	Private, via other means
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Insurance Carrier: _____		Policy Number: _____		Secondary Insurance Carrier: _____		Policy Number: _____

Highest Level of Education: <input type="checkbox"/> No Formal Education <input type="checkbox"/> Elementary Education (Grades 1-8) <input type="checkbox"/> Secondary Education, No HS Diploma (Grades 9-12) <input type="checkbox"/> Special Education Certificate or Completion of Attendance <input type="checkbox"/> High School Graduate or Equivalency Certificate <input type="checkbox"/> Post-Secondary Education, No Degree <input type="checkbox"/> Associate's Degree or Vocational Certificate <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree or Higher Do you have an IEP? <input type="radio"/> Yes <input type="radio"/> No	Name of high school you attend/attended: _____ Post-Secondary Education school attended: _____ Associate's/Vocational Cert. school attended: _____ Bachelor's Degree school attended: _____ Master's Degree or higher school attended: _____ Do you have a 504? <input type="radio"/> Yes <input type="radio"/> No	Are you currently a high school student? <input type="radio"/> Yes <input type="radio"/> No Date of Graduation: _____ Date of Graduation: _____ Date of Graduation: _____
--	--	---

Current Employment Status: <input type="radio"/> Employed - Full Time <input type="radio"/> Homemaker <input type="radio"/> Employed - Part Time <input type="radio"/> Self-Employed <input type="radio"/> Workshop/Shelter <input type="radio"/> Unpaid Family Worker <input type="radio"/> Migrant Seasonal Farm Worker <input type="radio"/> Not Employed - Trainee or Volunteer <input type="radio"/> Not Employed - Post Secondary Student <input type="radio"/> Not Employed - Other	If employed, what is your current salary? Hours/Week: _____ Earnings/Week: _____ When were you last employed? Month/Year: _____	Are you registered to vote? <input type="radio"/> Yes <input type="radio"/> No If no, would you like to be? <input type="radio"/> Yes <input type="radio"/> No
--	---	---

Please discuss your current skills, abilities and job interests?

Work History

Employer Name:		Employment Start	Employment End
Employer Address:			
City:		State:	Zip Code:
Your Job Title:		Supervisor:	Telephone Number:
Job Duties:			
Hours/Week:	Salary:	Reason for Leaving:	

Employer Name:		Employment Start	Employment End
Employer Address:			
City:		State:	Zip Code:
Your Job Title:		Supervisor:	Telephone Number:
Job Duties:			
Hours/Week:	Salary:	Reason for Leaving:	

Employer Name:		Employment Start	Employment End
Employer Address:			
City:		State:	Zip Code:
Your Job Title:		Supervisor:	Telephone Number:
Job Duties:			
Hours/Week:	Salary:	Reason for Leaving:	

Employer Name:		Employment Start	Employment End
Employer Address:			
City:		State:	Zip Code:
Your Job Title:		Supervisor:	Telephone Number:
Job Duties:			
Hours/Week:	Salary:	Reason for Leaving:	

Who referred you to DVR?

<input type="checkbox"/> Educational Institution (Elementary/Secondary)	<input type="checkbox"/> Education Institution (Post-Secondary)	<input type="checkbox"/> Community Rehabilitation Program
<input type="checkbox"/> Welfare Agency	<input type="checkbox"/> Social Security Administration	<input type="checkbox"/> One-Stop Employment Center
<input type="checkbox"/> Physician or Other Medical Personnel	<input type="checkbox"/> Private Residence (Family, Independent, etc.)	<input type="checkbox"/> Self-Referral
<input type="checkbox"/> Other Source	If Other Source, where? _____	

Are you currently working with any of the following agencies?

<input type="checkbox"/> American Indian VR Services Program	<input type="checkbox"/> Center for Independent Living
<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Community Rehabilitation Program
<input type="checkbox"/> Consumer Organization or Advocacy Group	<input type="checkbox"/> Education Institution (elementary/secondary)
<input type="checkbox"/> Educational Institution (post-secondary)	<input type="checkbox"/> Employer
<input type="checkbox"/> Employment Network	<input type="checkbox"/> Federal Student Aid (Pell grant, SEOG, work study, etc)
<input type="checkbox"/> Intellectual & Developmental Disabilities Agency	<input type="checkbox"/> Medical Health Provider (Public or Private)
<input type="checkbox"/> Mental Health Provider (public or private)	<input type="checkbox"/> No Service or Funding Provided
<input type="checkbox"/> One-stop Employment/Training Center	<input type="checkbox"/> Other Source
<input type="checkbox"/> Other State Agency	<input type="checkbox"/> Other VR State Agency
<input type="checkbox"/> Public Housing Authority	<input type="checkbox"/> SSA (Disability Determination Service or district office)
<input type="checkbox"/> State Department of Correction/Juvenile Justice	<input type="checkbox"/> State Employment Service Agency
<input type="checkbox"/> Veterans Administration	<input type="checkbox"/> Welfare Agency (state or local government)
<input type="checkbox"/> Workers Compensation	

Applicant Signature:	Date:
Parent/Guardian Signature (if applicant is under 18 years of age or has a legal guardian)	Date:
Counselor Signature:	Date: