Clear Form

DVR
Linking Ability & Business

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) 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 this application as much as possible to allow DVR to best serve you.

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:**	
Primary Phone Number:	**Secondary 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):	**Ethnicity: Are you Hispanic/Latino?**	**Marital Status:**	
☐ White/Caucasian ☐ American Indian Or Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander	◯ Yes ◯ No **Gender:** Female Male Other	☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed	**Are you a U.S. Citizen?** ◯ Yes ◯ No **If you answered no, are you legally able to work in the U.S.?** ◯ Yes ◯ No **Are you a veteran?** ◯ Yes ◯ No

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

What are your current living arrangements?

- Private Residence (Independent, Family, etc.)
- Community/Group Home
- Halfway House
- Homeless Shelter
- Other: _____
- Substance Abuse Treatment Facility
- Adult Correctional Facility
- Rehabilitation Facility
- Nursing Home

Who provides most of the money you need to support yourself?

- Own personal income
- Family/Friends
- Public Support (SSI, SSDI, TANF, etc.)
- Other

If Other: _____

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

Primary Insurance Carrier:	Policy Number:	Secondary Insurance Carrier:	Policy Number:

Highest Level of Education:

- No Formal Education
- Elementary Education (Grades 1-8)
- Secondary Education, No HS Diploma (Grades 9-12)
- Special Education Certificate or Completion of Attendance
- High School Graduate or Equivalency Certificate
- Post-Secondary Education, No Degree
- Associate's Degree or Vocational Certificate
- Bachelor's Degree
- Master's Degree or Higher

Name of high school you attend/attended: _____

Are you currently a high school student? ◯ Yes ◯ No

Post-Secondary Education school attended: _____

Associate's/Vocational Cert. school attended: _____ Date of Graduation: _____

Bachelor's Degree school attended: _____ Date of Graduation: _____

Master's Degree or higher school attended: _____ Date of Graduation: _____

Do you have an IEP? ◯ Yes ◯ No

Do you have a 504? ◯ Yes ◯ No

Current Employment Status:

- ◯ Employed - Full Time
- ◯ Employed - Part Time
- ◯ Workshop/Shelter
- ◯ Migrant Seasonal Farm Worker
- ◯ Not Employed - Post Secondary Student
- ◯ Homemaker
- ◯ Self-Employed
- ◯ Unpaid Family Worker
- ◯ Not Employed Trainee or Volunteer
- ◯ 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? ◯ Yes ◯ No

If no, would you like to be? ◯ Yes ◯ 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?

- Educational Institution (Elementary/Secondary)
- Education Institution (Post-Secondary)
- Community Rehabilitation Program
- Welfare Agency
- Social Security Administration
- One-Stop Employment Center
- Physician or Other Medical Personnel
- Private Residence (Family, Independent, etc.)
- Self-Referral
- Other Source _____

Are you currently working with any of the following agencies?

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

*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 with information regarding your beneficiary protections before enrollment. In the instance of a circumstance where it is impracticable to provide written notice of these protections prior to services, this notice must be provided at the earliest available opportunity. For the full listing of beneficiary protections please visit: https://www.ecfr.gov/current/title-34/section-75.712

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This information will be maintained as confidential

Delaware Division of Vocational Rehabilitation (DVR) Supplemental Information Form

The Division of Vocational Rehabilitation's (DVR) 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. As a federally funded program with eligibility guidelines, we must determine that the job seekers who apply meet these guidelines. The information we ask you to provide on this form will be used to determine your eligibility for the DVR program. Ensuring that the information is correct, and the form is complete assists in the eligibility process.

Applicant's Name: _____Birthdate: _____

Please list Primary Care Physicians, specialists, or therapists who have provided treatment.

Doctor Name: _____ Last Appt. _____

Specialty: _____

Address: _____

City: _____State _____Zip code _____

Phone #: _____ Fax #: _____ Email: _____

Doctor Name: _____ Last Appt. _____

Specialty: _____

Address: _____

City: _____State _____Zip code _____

Phone #: _____ Fax #: _____ Email: _____

Doctor Name: _____ Last Appt. _____

Specialty: _____

Address: _____

City: _____State _____Zip code _____

Phone #: _____ Fax #: _____ Email: _____

Please complete the next page

This information will be maintained as confidential

PLEASE LIST CURRENT PRESCRIPTIONS:	**Dosage?**	**How often taken?**	**Reason for Meds?**

Name of medication _____/ _____/ _____ /_____

Name of medication _____/ _____/ _____ /_____

Name of medication _____/ _____/ _____ /_____

Name of medication _____/ _____/ _____ /_____

Name of medication _____/ _____/ _____ /_____

Name of medication _____/ _____/ _____ /_____

Name of medication _____/ _____/ _____ /_____

Additional Medications:

ADDITIONAL INFORMATION (please mark where applicable)

Do you have a legal guardian? No ◯ Yes ◯ If yes, please list their name: _____
Phone #: _____

Do you have a criminal record? No ◯ Yes ◯ Year_____State_____ Misdemeanor ____ Felony ___

Are you on probation or parole? No ◯ Yes ◯

Do you have a probation or parole officer? No ◯ Yes ◯

If possible, please list the Officer's name and contact information: _____
Do you have a Driver's License? No ◯ Yes ◯ Driver's License State: _____

What do you rely on for transportation? My own car: ☐ DART bus: ☐ DART Paratransit: ☐
Family/Friends: ☐ Other: _____

Are you receiving services from other State agencies or nonprofits? No ◯ Yes ◯

If yes, please indicate which Agency: _____

Have you ever been in foster care? No ◯ Yes ◯

Are you currently a single parent? No ◯ Yes ◯

Have you ever been a DVR Transition Program participant? No ◯ Yes ◯