Application for Vocational Rehabilitation Services

Name ______________________ SSN ______________

What is your disability? ______________________________

Onset of Disability (month/year) ________________

Describe how your disability impairs your ability to work ?

What services do you need to go to work? ______________________

Have you ever applied for rehabilitation services? ☐ yes ☐ no
If yes when? ____________

Do you have a Ticket to Work? ☐ yes ☐ no

Have you ever been convicted of a felony? ☐ yes ☐ no

Have you ever defaulted on a student loan? ☐ yes ☐ no

I hereby apply for Vocational Rehabilitation Services in order to be employed.

I also grant the Missouri Office of Adult Learning and Rehabilitation Services the right to release and utilize information relative to my case to further my vocational rehabilitation as explained in the publication, "You and Vocational Rehabilitation."

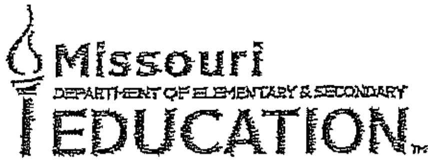
I understand that confidential information obtained by the Missouri Office of Adult Learning and Rehabilitation Services is protected by federal regulations and/or state law.

I understand this information will be utilized to determine my eligibility and the nature, scope and or provision of Vocational Rehabilitation Services needed for an employment outcome.

I have been provided a copy of the agency publication, "You and Vocational Rehabilitation," and it has been discussed with me. This publication contains information about the manner in which Vocational Rehabilitation services may be provided and my rights as an applicant, including the opportunity to exercise informed choice throughout the vocational rehabilitation process.

Client ______________________ Date ____________

Parent/Guardian/
Representative ______________________ Date ____________



Office of Adult Learning and Rehabilitation Services

Questionnaire for Vocational Rehabilitation Services

SSN: ____________________

AWARE Personal Information

Last Name ____________________ First Name ____________________ Middle Name ____________________

Preferred Name ____________________ Title/ Honorific ____________ (i.e Jr., II, MS, PhD., etc.)

Male ☐ Female ☐ Birth Date: ____________

Previous Last Name ____________________

Home Address ____
(Street, Route, P.O. Box #, etc.)

City: ____________ State: ______ Zip: ______ — ______ County: ____________

Mailing Address if different from above: ____________________________

Primary Phone Number ____________________ ☐ Voice ☐ TDD ☐ Fax

Second Phone ____________________ ☐ Voice ☐ TDD ☐ Fax

E-Mail Address: ____________________

RACE & ETHNICITY: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White

If Hispanic or Latino, check more than one. i.e. Hispanic & American Indian

What is your primary language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other

Citizenship Status: ☐ Employment Authorized Status ☐ Other ____________
☐ U.S. Citizen

Will you require any accommodations? ____________________________

____

Please list at least 2 people whom we may contact in an attempt to locate you, should your current contact information become outdated. Please include case managers, probation/parole, etc.

1. Last Name: ______ First Name: ______
   Relationship: ______ Address/City/Zip ______
   Home phone: ______ Mobile or work phone: ______
   E-Mail address: ______
2. Last Name: ______ First Name: ______
   Relationship: ______ Address/City/Zip ______
   Home phone: ______ Mobile or work phone: ______
   E-Mail address: ______

* * * * *

AWARE Application Information

Do you live in a private residence? ☐ yes ☐ no

If no, please describe: ______

Marital Status: ☐ divorced ☐ married ☐ never married ☐ separated ☐ widowed

Who referred you to us? ______

Number of family living in your household: ______ Number of dependents: ______

	Monthly Amount
What is your total Gross Family Monthly Income amount?	$

Who is your Primary Source of financial support? ______

Please check yes or no and provide monthly amount if you receive any of the following Public Support Types.

Question			
Do you receive Supplemental Security Income Aged benefits (SSI-A)?	☐ yes	☐ no	$
Do you receive Supplemental Security Income Disability benefits (SSI -D)?	☐ yes	☐ no	$
Do you receive Social Security Disability Insurance benefits (SSDI)?	☐ yes	☐ no	$
Do you receive disability benefits from the Veterans Administration (VA)?	☐ yes	☐ no	$
Do you receive TANF benefits from the Family Support Division?	☐ yes	☐ no	$
Do you receive General Assistance benefits from the Family Support Division?	☐ yes	☐ no	$
Do you receive Workers Compensation Benefits due to a work injury?	☐ yes	☐ no	$
Do you receive Other Disability cash benefits from any other source?	☐ yes	☐ no	$
Do you have any Other Public cash benefits not listed above?	☐ yes	☐ no	$
Total Household Monthly Income			$

Health Insurance, please check if you have:

☐ Medicaid (i.e. MO HealthNet)

☐ Medicare ☐ None

☐ Private Insurance through other means ☐ Private Insurance through own employment

☐ Public Insurance from other sources (i.e. Workers Compensation, VA Healthcare, etc.)

What is your level of Education? ____________________

Have you received services under an Individualized Education Program (IEP)? ☐ yes ☐ no

Are you currently a high school student ? ☐ yes ☐ no MOSIS# ____________

Transistion Program Participant ☐ yes ☐ no

High School

School Name ____________________ City & State ____________________

Highest Grade Completed ____________________ Dates Attended ____________________

Other Training

School Name ____________________ City & State ____________________

Area of Study ____________________ Graduated / Completed ☐ yes ☐ no

Degree/Certificate Earned ____________________ Dates Attended ____________________

List Your Last Two Jobs:

1. ____
(Employer Name & Address) (Job Title) (Weekly Hours and Salary)

____
(Dates Employed: MM/YY – MM/YY) (Disability-Related Problems Affecting job)

2. ____
(Employer Name & Address) (Job Title) (Weekly Salary)

____
(Dates Employed: MM/YY – MM/YY) (Reason for leaving)

3. Other Work Experience: ____

____

____

* * * * *

AWARE Special Programs

Have you been referred by or receiving services from the following programs? If so check box.

☐ COOP Program (High School) ☐ Center for Independent Living (CIL) Referral

Are you a Veteran? ☐ yes ☐ no

(If yes, list dates of service) ______________________________

Do you have a Military Service Connected Disability? ☐ yes ☐ no

Migratory or Seasonal Farm Worker Program? ☐ yes ☐ no

Projects with Industry? ☐ yes ☐ no

CONSENT FOR RELEASE OF INFORMATION

(Use this form for information SSA generates and includes on a BPQY)

*SSA will not honor this form unless all required fields have been completed (*signifies required field)*

TO: *Social Security Administration*

*Name ______ * Date of Birth ______ * Social Security Number ______

I authorize the Social Security Administration to release information or records about me via facsimile, phone, email or postal correspondence, to: (name, address, agency, contact information including phone and email)

Name, Title	Contact Information
	Vocational Rehabilitation 9900 Page Ave., Suite 104 St. Louis, MO. 63132 Tele: 314-587-4866 Fax: 314-877-1530

I want this information released for benefit planning purposes. I want accurate and current information about my benefits to learn how they would be affected by work. This is a "program–related" purpose.

Please release the following information selected from the list below:

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [x] Current monthly Social Security benefit amount
- [x] Current monthly Supplemental Security Income payment amount
- [x] My Medicare entitlement
- [x] *Other (specify below)*

Cash: Type of Benefit(s), current payment status, statutory blindness, date of disability onset, date of entitlement, others paid on the record, total family cash benefit, overpayment balance, monthly amount withheld.
Medical Reviews: Next medical review, medical re-exam cycle
Representation: Representative payee, authorized representative
Title XVI (SSI) Work Exclusion: Blind work expenses, impairment-related work expenses, student earned income exclusions, pass exclusion, SSI earnings
Title II (SSDI) Work Exclusion: Trial Work Period start/end date, months used, month of cessation, and last work review action.
SSI/SSDI Posted Monthly Earnings for last 5 years

Additional Information Requested:

IRWE and/or Subsidy Information: Please provide specifics for any IRWE and/or subsidy, if applicable
Ticket-to-Work: If a "ticket" is assigned, please indicate when was it assigned, and include the EN's contact information.
1619b Status: If the person is in non-pay due to wages, do they have 1619b status?
What is the disabling condition(s) for which I receive benefits?

Other necessary information requested:

______

______

I am the individual, to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

Signature: ______

(Show signatures, names and addresses of two people if signed by mark.)

*Date: ______ *Relationship: (if not the individual) ______

*Daytime Phone: ______

CONSENT FOR RELEASE OF INFORMATION

(Use this form for the non-certified yearly earnings provided on the BPQY)

*SSA will not honor this form unless all required fields have been completed (*signifies required field)*

TO: *Social Security Administration*

*Name ______ * Date of Birth ______ * Social Security Number ______

I authorize the Social Security Administration to release information or records about me via facsimile, phone, email or postal correspondence, to: (name, address, agency, contact information including phone and email)

Name, Title	Contact Information
	Vocational Rehabilitation 9900 Page Ave., Suite 104 St. Louis, MO. 63132 Tele: 314-587-4866 Fax: 314-877-1530

I want this information released for benefit planning purposes. I want accurate and current information about my benefits to learn how they would be affected by work. This is a "program–related" purpose.

Please release the following information listed below:

☒ **Non-certified yearly totals of my earnings from my date of birth to the present.**

Other necessary information requested:

______

______

I am the individual, to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

Signature: ______

(Show signatures, names and addresses of two people if signed by mark.)

*Date: ______ *Relationship: (if not the individual) ______

*Daytime Phone: ______

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, ____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

☐ Department of Mental Health (DMH)
☐ Department of Health and Senior Services (DHSS)
☐ Department of Social Services (DSS)
☐ Department of Elementary and Secondary Education (DESE)
☐ Other ____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)

to **(check all that apply)**

☐ Department of Mental Health (DMH)
☐ Department of Health and Senior Services (DHSS)
☐ Department of Social Services (DSS)
☐ Department of Elementary and Secondary Education (DESE)
☐ Other ____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☐ Eligibility Determination
☐ Assessment
☐ Aftercare
☐ Placement
☐ Transfer/Treatment
☐ Treatment Planning
☐ Continuity of Services/Care
☐ Conditional/Unconditional Release Hearing
☐ At Consumer's Request

☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the ______________________ program (please complete the name of the program in which you want to participate)

☐ Other (specify) ____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

☐ Discharge Summary
☐ Progress Notes
☐ Treatment Plan and/or Review
☐ Social Service Assessment
☐ Educational testing, IEP, transcript, and/or grading reports
☐ Medical/Psychiatric Assessment(s)
☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
☐ Other ____

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

   ____

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
4. This authorization becomes effective on ______________________. This authorization automatically expires on the following date, event or special condition ______________________________________.
5. If I fail to specify an expiration date, this authorization will expire in one year.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE

I, ______________________________, (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

HEALTH ASSESSMENT QUESTIONNAIRE

NOTE ► THIS QUESTIONNAIRE WILL BE USED BY VOCATIONAL REHABILITATION TO ASSESS YOUR CURRENT HEALTH AND TO EVALUATE THE NEED FOR FURTHER MEDICAL INFORMATION.

PART I. IDENTIFICATION INFORMATION

LAST NAME	FIRST NAME	MI

WHAT IS YOUR DISABILITY?

IN YOUR OWN WORDS, HOW DOES YOUR DISABILITY INTERFERE WITH YOU GETTING OR HOLDING A JOB?

PART II. CURRENT MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN

NAME OF DOCTOR		DATE OF LAST VISIT
ADDRESS		REASON
DATES OF TREATMENT	TELEPHONE	

ARE YOU CURRENTLY RECEIVING TREATMENT FOR ANY PHYSICAL OR MENTAL PROBLEM?

☐ YES ☐ NO IF YES, PROVIDE A BRIEF DESCRIPTION

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

☐ YES ☐ NO IF YES, LIST MEDICATIONS

LIST ALL MEDICAL PROFESSIONALS FAMILIAR WITH YOUR DISABILITY.

NAME OF DOCTOR(S)		NAME OF DOCTOR(S)	
ADDRESS		ADDRESS	
DATES OF TREATMENT	TELEPHONE	DATES OF TREATMENT	TELEPHONE

LIST ANY HOSPITALS WHERE YOU HAVE RECEIVED TREATMENT FOR YOUR DISABILITY.

NAME OF HOSPITAL (MOST RECENT HOSPITALIZATION)	NAME OF HOSPITAL
ADDRESS	ADDRESS
DATES OF TREATMENT	DATES OF TREATMENT

PART II: REPORTED MEDICAL HISTORY

DURING THE PAST TWO YEARS, HAVE YOU RECEIVED TREATMENT FOR ANY OF THE FOLLOWING AREAS:

A. ENT: EYES, EARS, NOSE, THROAT ☐ YES ☐ NO

B. NEUROLOGICAL: FREQUENT HEADACHES, DIZZINESS, STROKE, EPILEPSY, SEIZURE DISORDER ☐ YES ☐ NO

HAVE YOU EVER HAD A HEAD INJURY OR CONCUSSION? ☐ YES ☐ NO

C. RESPIRATORY: BREATHING, CHEST/LUNGS, CHRONIC COUGH, SHORTNESS OF BREATH, EMPHYSEMA, ASTHMA ☐ YES ☐ NO

D. CARDIOVASCULAR: HEART, BLOOD VESSELS, RHEUMATIC FEVER, MURMUR, PALPITATION, CHEST PAINS, HIGH BLOOD PRESSURE ☐ YES ☐ NO

E. INTERNAL: STOMACH, CHRONIC INDIGESTION, ULCERS, COLITIS, GALL BLADDER, LIVER, KIDNEY, BLADDER, PROSTATE, GENITOURINARY ☐ YES ☐ NO

F. ENDOCRINE: DIABETES, THYROID ☐ YES ☐ NO

G. ORTHOPEDIC: NEURITIS, ARTHRITIS, GOUT, ANY DISORDER OF THE MUSCLES, BONES, OR JOINTS ☐ YES ☐ NO

H. ONCOLOGY: CANCER, TUMOR, CYST, OR ANY OTHER DISORDER OF THE SKIN OR LYMPH GLANDS ☐ YES ☐ NO

I. PSYCHIATRIC: DEPRESSION OR OTHER EMOTIONAL DISORDER ☐ YES ☐ NO

J. INFECTIOUS DISEASES: HEPATITIS, TUBERCULOSIS, HIV/AIDS ☐ YES ☐ NO

K. SUBSTANCE ABUSE: ALCOHOLISM, DRUGS ☐ YES ☐ NO

L. OTHER: HAD, OR BEEN ADVISED TO HAVE, ANY SURGICAL PROCEDURES, HOSPITALIZATIONS, MEDICAL EXAMINATIONS OR CONSULTATIONS NOT ALREADY MENTIONED ☐ YES ☐ NO

CONSULTED A PHYSICIAN, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER PRACTITIONER FOR ANY REASON NOT MENTIONED ABOVE ☐ YES ☐ NO

IF THE ANSWER IS YES TO ANY OF THE ABOVE, PROVIDE A BRIEF EXPLANATION. INCLUDE NAME AND ADDRESS OF THE DOCTOR(S) AND HOSPITAL(S)

PLEASE LIST (DESCRIBE) ANY OTHER DISABILITY(IES) NOT LISTED ABOVE SUCH AS ADHD, LEARNING PROBLEMS, LEARNING DISABILITY, DYSLEXIA, ETC.

REVIEWED MEDICAL INFORMATION WITH CLIENT: DATE __________ COUNSELOR'S INITIALS __________

TO HELP US PROCESS YOUR APPLICATION FOR SERVICES, PLEASE PROVIDE YOUR COUNSELOR WITH COPIES OF ANY HEALTH INFORMATION THAT YOU MAY HAVE IN YOUR POSSESSION.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE (IF UNDER THE AGE OF 18, PARENT OR GUARDIAN MUST SIGN)	DATE	PARENT OR GUARDIAN SIGNATURE	DATE