

**EDWARD E. SMITH**

Vocational Rehabilitation Counselor  
Adult Career and Continuing Education  
Services-Vocational Rehabilitation



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ACCES-VR  
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Please return the completed form to:

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of Adult Career and Continuing  
Education Services-Vocational Rehabilitation  
(ACCES-VR)

Application for VR Services

VR-04 (7/14)

Please print or type all entries

<b>NAME</b> Last First Middle Initial			<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
If you have been known by another name, enter here: Last First Middle Initial				
<b>HOME ADDRESS</b> Street Apartment Number				
City State Zip + 4 Code County			<b>SOCIAL SECURITY NUMBER</b> □□□-□□-□□□□	
If your <b>MAILING ADDRESS</b> is different than your home address, please complete the mailing address information below.				
<b>MAILING ADDRESS</b> Street Apartment Number				
City State Zip + 4 Code County				
PHONE NUMBER(S) where we can reach you or leave a message: Area code Area code 1. ( ) - 2. ( ) Home <input type="checkbox"/> Cell <input type="checkbox"/> Other <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other <input type="checkbox"/> Email: _____			Best time to call 1. 2.	
DATE OF BIRTH Month Day Year □□-□□-□□				
Race/Ethnicity-Choose <u>ALL</u> that apply. If left blank ACCES will complete. If Hispanic or Latino is checked, please check additional box.			<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (includes Indian Subcontinent) <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	
What is your disability?			Who referred you to us?	
			MARITAL STATUS: (Circle Response) (1) Married; (2) Widowed; (3) Divorced (4) Separated (5) Never Married	
I hereby apply for rehabilitation services: Date _____			Signature of applicant, parent, or legal guardian.	
<b>X</b> (Sign here.)				

• • • Please answer the questions below and on the back of this form. • • •

You do not have to answer these questions now, but your answers will help ACCES-VR process your application.

Have you ever received services from ACCES-VR or its former name, the Office of Vocational and Educational Services for Individuals with Disabilities (VESID)?..... ☐ Yes ☐ No

Are you now receiving services from one or more agencies?..... ☐ Yes ☐ No

If you answered yes, indicate agency name(s), address(es) and contact person(s):

(1)

(2)

Describe how your disability limits your ability to work.

What services are you seeking from ACCES-VR?

Are you disabled because of a work-related injury? ☐ Yes ☐ No

Do you use any assistive devices or aids? ☐ Yes ☐ No

Do you have a NYS driver's license? ☐ Yes ☐ No

Do you have a driver's license from a state other than New York? ☐ Yes ☐ No

Do you have access to a motor vehicle? ☐ Yes ☐ No

Do you use public transportation? ☐ Yes ☐ No

Are you able to leave your home? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Are you a citizen of the United States? ☐ Yes ☐ No

If no, are you legally permitted to work in this country? ☐ Yes ☐ No

Check the benefits you now receive?

☐ SSI ☐ SSDI ☐ Workers Compensation

☐ Other, specify \_\_\_\_\_

Do you regularly see a doctor or clinic about your disability? ☐ Yes ☐ No, If yes, indicate date of last visit: \_\_\_\_\_

Please provide the name and address of doctor(s) and clinic(s):

(1) (2)

Circle the highest grade you have successfully completed, and check the applicable box(es)

1 2 3 4 5 6 8 9 10 11 12

GED or High School

13 14 15 16

17

20

Equivalency Diploma ☐ Yes ☐ No

College

Graduate School

Doctorate

Special Education ☐ Yes ☐ No Do you now attend high school? ☐ Yes ☐ No Indicate college degree(s) earned: \_\_\_\_\_

Name and address of school you last attended: *Name of School* *Address*

**List below other people in your household**

Full Name	Age	Their Relationship to You

**List below the people ACCES-VR can contact if we are unable to reach you using the information on page 1.**

Name	Address	Phone

**List below your work history (include attachments for additional jobs, if necessary)**

Employer Name and Address	Dates Employed From - To	Weekly Earnings	Job Title and Duties, and Reason for Leaving

**Persons applying for or receiving rehabilitation services have the right to have any actions or decisions of this Office reviewed. A description of the review process and form can be obtained from any ACCES-VR District Office.**

**All information will be kept confidential and is subject to verification.**

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## ACCES-VR High School Applicant Supplemental Data

**All Information Below is Optional but Helpful for Application**

### ***Education Information to be completed by person making referral***

Referral will be facilitated by including **one or more** of the following: ☐ Current IEP and most recent psychological report  
☐ Current 504 Plan and supporting documents ☐ Current Physician Report with diagnosis ☐ Other Relevant Information

Student Name: \_\_\_\_\_ DOB \_\_\_\_\_

CSE Classification, 504 or Medical Diagnosis: \_\_\_\_\_

Grade Most Recently Completed: \_\_\_\_\_ Expected Year of School Completion: \_\_\_\_\_

Type of Degree/Certificate Anticipated: ☐ Regents ☐ Local ☐ CDOS ☐ Skills & Achievement

School District Student Resides In: \_\_\_\_\_

School Student Attends: \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

Name of person making referral: \_\_\_\_\_ Title: \_\_\_\_\_

Email Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### ***Can Choose to Complete Following with ACCES-VR Counselor at First Meeting***

#### ***Health, Residence & Work Questionnaire: To Be Completed By Student And Parent/Guardian***

Do you have or have you ever had any of the following conditions?

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> ADHD             | <input type="checkbox"/> Depression           | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Seizure Disorder                  |
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Skin Disease/Rash                 |
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Drug/Alcohol Abuse   | <input type="checkbox"/> Learning Disability     | <input type="checkbox"/> Speech/Language Disorder          |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Mental Illness          | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Autism Spectrum  | <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Muscular Dystrophy      | <input type="checkbox"/> Ulcers/Colitis/Crohn's Disease    |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Orthopedic Limitations  | <input type="checkbox"/> Vision (not corrected by glasses) |
| <input type="checkbox"/> Cerebral Palsy   | <input type="checkbox"/> HIV Related Diseases | <input type="checkbox"/> Respiratory Disorder    | <input type="checkbox"/> Other: _____                      |

List of Medications: \_\_\_\_\_

#### ***Medical Insurance at Application:***

☐ Medicaid ☐ Medicare ☐ Other Private ☐ Private Through Employment ☐ Workers Compensation ☐ None

#### ***Living Arrangements at Application:***

☐ Private Residence ☐ Foster Care ☐ Homeless ☐ Community Residence ☐ Halfway House  
☐ Substance Abuse Treatment Facility ☐ Mental Health Facility ☐ Correctional Facility ☐ Other

#### ***Work Status at Application:***

☐ Employed with a job coach ☐ Employed on my own ☐ Not presently employed



**Authorization to Obtain/Release Information  
VR-21 (02/2025)**

<b>Name:</b>	<b>Date of Birth:</b>	<b>Aware ID#:</b>
<b>Address:</b>		

The Office of Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) has my permission to obtain or release information from/to individuals, government agencies and other necessary entities (including the Client Assistance Program, also known as CAP), and/or employers involved with my vocational rehabilitation.

I, or my authorized representative, understand that:

- All information will be treated as confidential.
- My confidential information may be sent and received electronically.
- This information may include, but is not limited to, reports about my disability, education records, social security administration information, records related to parole or probation, documents necessary to determine my financial need, and/or other information ACCES-VR may need to determine my eligibility for services, provide me with vocational rehabilitation services, and/or refer me to other services needed to obtain or maintain my employment goals.
- The information shared or obtained will be used exclusively for the purpose of assisting me in obtaining or maintaining my employment goals.
- I can withdraw my permission at any time regarding the releasing or obtaining of information by notifying ACCES-VR in writing (Note: This will not affect actions already taken with my permission).
- ACCES-VR may need to use the information obtained from this authorization to administer the vocational rehabilitation program.
- This authorization is valid for the life of my case unless it is withdrawn.

I have read all the information in this section and understand that ACCES-VR's 102.00 Confidentiality Policy is located at <http://www.acces.nysed.gov/vr/10200-confidentiality-policy>. Information regarding ACCES-VR's Confidentiality Policy was clearly explained to me, and I have read all the information on this form.

☐

**By initialing this box, I am authorizing the release of my entire record.**

(If you have initialed the box, proceed to "the purpose for this authorization is as follows" section of this form.)

**The following information which may be released or obtained, subject to this signed authorization, is as follows:**

<input type="checkbox"/> Psychological Assessment Reports	<input type="checkbox"/> Vocational Evaluation Reports	<input type="checkbox"/> Education Records
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Other:	

**The purpose for this authorization is as follows:**

<input type="checkbox"/> Eligibility Determination	<input type="checkbox"/> Plan Development	<input type="checkbox"/> Referral for Services
<input type="checkbox"/> Assessment	<input type="checkbox"/> Individual's Request	<input type="checkbox"/> Other:

Name and Address of Program/School Releasing this Information:

**Auburn High School 250 Lake Ave Auburn, New York 13021**

Name and Address of Person(s) to Whom this Information Will be Disclosed:

**ACCES- VR 333 East Washington St Syracuse, New York 13202**

**My signature below proves my understanding, agreement, and consent to release this information.**

If not the individual, name of person signing form:	Identify the relationship of the authority signing on behalf of the individual:
---	---

\_\_\_\_\_  
Signature of the Individual or Authorized Representative

\_\_\_\_\_  
Date

This authorization to obtain and release information was developed to comply with the provisions regarding disclosure of education, and other information under P.L. 104-191 (HIPAA); 34 CFR 361.38; 45 CFR parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g (FERPA); 34 CFR parts 99 and 300. This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit further disclosure of this information except with the specific written consent of the person to whom it pertains.

## **Authorization to Release / Obtain Information**

### **Instructions**

This *Authorization to Release / Obtain Information* form is to be used when information is to be released by or is to be requested by ACCES-VR. All such information will be treated as confidential and privileged and used only for the purposes of ACCES-VR services. Information ACCES-VR may have in the records, but obtained via a release from another provider, may be restricted from further dissemination.

If at any time the consumer wishes to terminate this release, he/she may do so by writing to ACCES-VR. Withdrawal of permission to release/obtain confidential information will not retroactively cover any information that has already been released or obtained.

**You must:**

- be as specific and precise as possible;
- not leave any questions unanswered;
- include a specific date on which the permission will end;
- include names of persons and titles or organization name receiving or sending information; and
- mark the VES-22 as void If the consumer rescinds his/her permission in writing to release/obtain further information.

**Box #1:** State the exact information that will be released/obtained (e.g., Medical Evaluation by Dr. Diaz dated 1/16/94; Educational Summary dated 10/5/95 from John Jay High School).

**Box #2:** State the name and title (if known) of the person releasing the information (e.g., Ms. Jean Jones, Vocational Rehabilitation Counselor; Dr. Browne, School Psychologist).

**Box #3:** Complete the name, title, and address of the person receiving the information. If a ACCES-VR counselor is sending the same document to several sources (e.g., a general medical report to a medical specialist and to an intake worker at a facility), multiple names, addresses, and titles can be filled in this box. It is not sufficient to indicate the report will be sent to a facility or program. ***A specific individual must be indicated***, so that individual becomes responsible for the confidential information.

**Box #4:** Provide a brief summary that indicates why the information is needed.

***The consumer or parent/guardian must sign and date the form at the bottom. This date sets the timeframe for which information may be exchanged under this release form. If a different expiration date is to be established this must be indicated on the form.***

## ***Information Release Authorization***

Name: \_\_\_\_\_  
*Print full name*

The Office of Adult Career and Continuing Education Services (ACCES-VR) has my permission to release or obtain information from agencies [including the Client Assistance program (CAP)], individuals, or employers as are concerned with my vocational rehabilitation. This information may include reports about my physical or mental condition, official school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services.

I understand that:

- All such information will be treated as confidential and privileged;
- The information will be used only for the purpose of obtaining services offered through ACCES-VR;
- I can withdraw my permission to release or obtain information by writing to ACCES-VR (this will not affect actions already taken with my permission); and
- ACCES-VR may need to use the information to administer the vocational rehabilitation program

\_\_\_\_\_  
***Signature***

\_\_\_\_\_  
***Date***

\_\_\_\_\_  
***Parent/Guardian Signature (If Under 18 Years of Age)***

\_\_\_\_\_  
***Date***

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## YOUR RESPONSIBILITIES

- o Keep all appointments with my ACCES-VR counselor
- o Let my counselor know if I change my address or phone number or email
- o Follow medical and treatment recommendations
- o Send my counselor my grades or progress reports
- o Let my counselor know if I have any problems that will interfere with my plan
- o Contact my counselor when I get a job!

Fill in this information at your first meeting with your VR counselor.

My counselor (VRC) is \_\_\_\_\_

Phone \_\_\_\_\_

Email address \_\_\_\_\_

Counselor's assistant (VRCA) is \_\_\_\_\_

Phone \_\_\_\_\_

Email address \_\_\_\_\_

## THE ACCES-VR PROCESS

- o Student makes an informed choice to apply for ACCES-VR
- o Student completes application packet
- o VR Counselor determines eligibility
- o VR Counselor and student choose an appropriate employment goal
- o VR Counselor and student develop an Individualized Plan for Employment (IPE)
- o Student acquires skills and supports
- o Student gets and keeps a job
- o VR Counselor closes case as a **SUCCESS!**

## KEEPING IN TOUCH WITH ACCES-VR

- o **By telephone to your VRC or VRCA**  
Listen to the message - it is often customized to let the caller know the person's schedule and activities  
Leave a clear message - your name, your phone number, what you are calling about, and times to call you back
- o **By mail** - note the counselor's name on the envelope
- o **By email** - sometimes the quickest
- o **By appointment** - be responsible - arrive on time - call ahead to cancel if you can't make it

\*\*\*\*BRING THIS TO YOUR 1<sup>ST</sup> MEETING WITH YOUR ACCES-VR COUNSELOR\*\*\*\*

Syracuse District Office  
State Office Building Room 230  
333 East Washington Street  
Syracuse NY 13202  
(315) 428-4179

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## ACCES VR

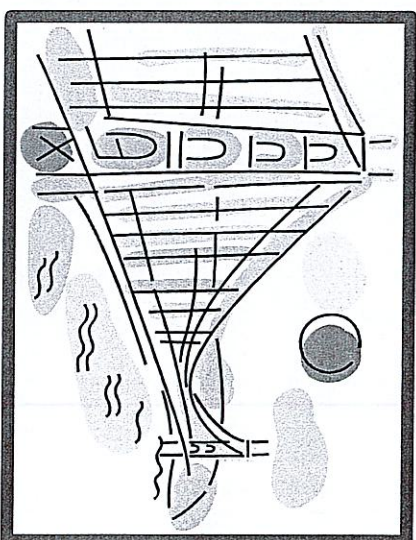
Adult Career and Continuing Education Services - Vocational Rehabilitation

a proud partner of the American Job Center/network

## USER-FRIENDLY GUIDE TO TRANSITION SERVICES

FOR

HIGH SCHOOL STUDENTS,  
THEIR PARENTS, AND THEIR  
TEACHERS



a bridge to your future

The University of the State of New York  
The State Education Department  
Adult Career and Continuing Education Services  
Vocational Rehabilitation  
Albany, New York 12234  
<http://www.acces.nysed.gov/vr>



## APPLYING FOR ACCES-VR SERVICES

IEP/CSE planning or other school discussions prior to junior year should include the consideration of a referral to ACCES-VR so that you can make an **informed choice** about applying. You don't need to have an IEP to apply!

Transition staff at your school will help you decide when you should apply, help you complete forms, send forms home for your parent or guardian to complete/sign, and send the entire packet to ACCES-VR once it's complete.

ACCES-VR is **Voluntary**. You choose if you want to apply for services or not.

## ELIGIBILITY FOR ACCES-VR SERVICES

There are four things student and counselor must establish to determine eligibility for ACCES-VR services.

- That the student has a *disability*
  - That the disability creates a *barrier* to employment
  - That the student can *benefit* from rehabilitation services
  - That *vocational rehabilitation services are required* to achieve employment
- Having an IEP or a 504 plan does not guarantee eligibility for ACCES-VR. All of the above criteria must be met according to federal vocational rehabilitation guidelines.
- Important steps:
- When you are determined eligible or ineligible you will get a letter.
  - If you are eligible, services will not begin until you have met with your counselor and developed a plan.

## MEETING WITH YOUR ACCES-VR COUNSELOR

While you are still attending high school:

- You may meet at your school.
- Your parent or guardian will be invited
- A transition staff person at the high school will help schedule these meetings.

At the first meeting:

- Your ACCES-VR counselor will talk with you about your plans when you leave high school.
- You will talk about your ideas about a job goal and the services you will need to become employed.

Once you leave high school:

- Meetings will be at our district office or in a community location.
- You will schedule these meetings directly with your ACCES-VR counselor.

## DEVELOPMENT OF THE EMPLOYMENT GOAL

Everything ACCES-VR does is directed toward helping you to reach an employment goal.

You will meet with your ACCES-VR counselor as often as you need, to:

- Choose a realistic and achievable goal.
- Decide how you will gain the skills you will need to do the job.
- Decide what help you need to find a job.
- Figure out what supports you need to keep a job and who will be able to provide them.

## SERVICES TO HELP YOU GET A JOB

All services are directed toward helping you to reach an **employment goal** and are based on your **individual** needs.

Examples of types of services include:

- Vocational counseling
  - Assessment for career planning
  - Assessment for assistive technology needs
  - Purchase of assistive technology (\*)
  - Funding toward the cost of education or training after high school (\*)
  - Assistance with some transportation costs (\*)
  - Funding for academic support services (note takers, tutors)
  - Job readiness and job placement services to help you get and keep a job (may include job coaching)
- \*means family income is considered

ACCES-VR is **MORE** than financial assistance.

- Yet some services ARE based on your family income (\*) - see above
- You may need to provide your family tax return and records of expenses annually.

