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

NAME *Last*	*First*	*Middle Initial*	GENDER ☐ Male ☐ Female

If you have been known by **another name**, enter here: *Last* *First* *Middle Initial*

HOME ADDRESS *Street* *Apartment Number*

City *State* *Zip + 4 Code* *County* SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

If your **MAILING ADDRESS** is different than your home address, please complete the mailing address information below.

MAILING ADDRESS *Street* *Apartment Number*

City *State* *Zip + 4 Code* *County*

PHONE NUMBER(S) *where we can reach you or leave a message:*
Area code
1. ( ) -
Home ☐ *Cell* ☐ *Other* ☐
Area code
2. ( )
Home ☐ *Cell* ☐ *Other* ☐

*Email:*_____

Best time to call
1.
2.

DATE OF BIRTH
Month Day Year
☐☐-☐☐-☐☐

Race/Ethnicity-Choose ALL that apply. If left blank ACCES will complete. If Hispanic or Latino is checked, please check additional box.

☐ American Indian or Alaska Native
☐ Asian (includes Indian Subcontinent)
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ 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: *Signature of applicant, parent, or legal guardian.*
*Date*_____

X *(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 Equivalency Diploma ☐ Yes ☐ No | 13 14 15 16 College | 17 Graduate School | 20 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.

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?

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

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

Authorization to Release / Obtain Information

(Please read instructions on page two before completing this form.) **VR-22 (3/12)**

CONSUMER NAME	**CONSUMER ID NUMBER**

CONSUMER ADDRESS ***[include street (apartment number or building, if applicable), city, state, zip]***

Adult Career & Continuing Education Services-Vocational Rehabilitation (ACCES-VR) has my permission to release or obtain information indicated in item #1 below. This information may include reports about my physical or mental condition, 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 this information will be treated as confidential and privileged and will only be used for the purpose of obtaining services offered through ACCES-VR.

I can change my mind about this release, by telling ACCES-VR in writing that I do not want any further information to be given out. I understand that information disclosed according to this consent may be subject to redisclosure and will no longer be subject to the HIPPA privacy requirements. This will not affect actions already taken with my permission.

My permission to release or obtain information expires on date _____ or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released or obtained? *(Be specific.)*
Most recent Psychological Evaluation with IQ scores
Individualized Education Plan (IEP) or 504 Plan
Employability Profile
Career Plan
Student Exit Summary
Transcripts

2. Who is releasing this information? *(Insert the full name of this person or organization.)*
Auburn High School -250 Lake Ave, Auburn, NY 13021

3. Who is receiving this information? *(Insert complete information about this person.)*

Name: *Edward E. Smith*
Title: ***Vocational Rehabilitation Counselor***
Address: ***333 E. Washington St. Syracuse New York 13202***

4. Why is this information needed? **To determine eligibility for ACCES-VR services and to assist with vocational planning**

I have read all of the information on this form. I understand and agree to what it says.

Consumer or Parent/ Guardian Signature: _____ *Date:* _____

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records. Form VES-540, *Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Alcoholism or Substance Abuse,* must be attached to this form when necessary.

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.

THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services (ACCES-VR)

VR-21 (3/15)

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***

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its educational programs, services, and activities. Inquiries concerning this policy of nondiscrimination should be referred to the Department's Office for Diversity, Ethics, and Access, Room 530, Education Building, Albany, NY 12234-0001.

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