



APPLICATION FOR VOCATIONAL REHABILITATION SERVICES (continued)

**Education and Work Experience**

EDUCATION	DATES ATTENDED	HIGHEST GRADE COMPLETED	DID YOU GRADUATE?
<b>High School LAST attended:</b>			
Name: _____	From: _____	1 2 3 4 5 6 7 8	Yes: <input type="checkbox"/>
Location: _____	To: _____	9 10 11 12	No: <input type="checkbox"/>
Did you receive Special Education Services? Yes: <input type="checkbox"/> No: <input type="checkbox"/>			
High School Equivalent: GED <input type="checkbox"/> USAF <input type="checkbox"/> Other <input type="checkbox"/> Date: _____			
<b>Business or Vocational School:</b>		Dates Attended:	Completed?
Name: _____		From: _____	Yes: <input type="checkbox"/>
Location: _____		To: _____	No: <input type="checkbox"/>
Area of Study: _____			
<b>College or University</b> (list additional college training on back side of this sheet)		Dates Attended:	Completed?
Name: _____		From: _____	Yes: <input type="checkbox"/>
Location: _____		To: _____	No: <input type="checkbox"/>
Degree Received: AA <input type="checkbox"/> BA/BS <input type="checkbox"/> MA/MS <input type="checkbox"/> Other <input type="checkbox"/>			
Major: _____ Minor: _____			
Please list any additional certifications, training or special classes: _____			

Do you want to register to vote today? Yes:  No:

**MILITARY EXPERIENCE:** Yes:  No:

If yes: Branch: \_\_\_\_\_ Dates: \_\_\_\_\_

Discharge: Honorable  Medical  Dishonorable

Do you have a service connected disability? Yes:  What percentage? \_\_\_\_\_ No:

Duties: \_\_\_\_\_

**What is your family income?** \_\_\_\_\_

Do you receive SSI or SSDI? Yes:  No:  Amount: \_\_\_\_\_

**Do you have medical benefits?** Yes:  No:

Health Insurance:  Medicare:  State Medicaid

If Health Insurance, indicate with whom: \_\_\_\_\_

**Do you have transportation?** Yes:  No:

Personal Vehicle:  Public Transportation:  Other:

Are you involved in other job training or placement programs? \_\_\_\_\_

Do you owe any fines, penalties or child support arrearages that could affect your employability? Yes:  No:

**Have you ever been convicted of a felony?** Yes:  No:

If yes please explain: \_\_\_\_\_  
\_\_\_\_\_

If currently on Parole or Probation who is your probation officer? \_\_\_\_\_ telephone: \_\_\_\_\_

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Work Experience

WORK HISTORY:

CHECK HERE IF NO WORK HISTORY:

If currently working how many hours per week do you work? \_\_\_\_\_ hourly wage \_\_\_\_\_

List current or last job first. If you run out of space you may continue on the back side of this sheet.

**Employer:** \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Job Duties: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Job Duties: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Job Duties: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Job Duties: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Job Duties: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Job Duties: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

APPLICATION FOR VOCATIONAL REHABILITATION SERVICES (continued)

**Attachment to Application**

**CONFIDENTIAL PERSONAL INFORMATION**

The Bureau of Vocational Rehabilitation is a state and federally funded agency that assists persons with disabilities in achieving or maintaining employment. I understand that it is necessary for the Bureau to collect personal information in connection with my rehabilitation program. I understand that such information will be collected, to the maximum extent practicable from me. All personal information in the possession of the Bureau may be used only for the purposes directly connected with the provision of services and the administration of the program under which services are provided.

I understand that information is available to me when requested in writing, except where the Bureau believes such information can reasonably be expected to cause physical or emotional harm. In this instance, the Bureau shall release such information through a qualified medical or psychological professional or to an authorized representative.

Any information provided by me is subject to verification and review through the Social Security Administration.

I understand that my eligibility and/or provision of services may be impacted if I refuse to provide personal information that is requested by the Bureau.

I understand that my personal information will be held confidential by the Bureau and will not be disclosed to any other person or entity except:

- 1) When a properly signed Release of Information form, conditioned and dated, is presented, or;
- 2) For purposes directly connected with the provision of services and/or the administration of the rehabilitation program under which services are provided.
- 3) For reasons in accordance with the stated regulations and/or any other applicable federal law, state law, policy or regulation
- 4) BVR/BSBVI may share information with Job Connect Partners for the purpose of scheduling individuals who are seen at the Job Connect offices or to assist individuals with their job search.

BVR/BSBVI may provide specific information to other Job Connect Partners when working in collaboration with the partner on behalf of the individual. The Job Connect partners sign confidentiality agreements in which they agree to keep all information provided to them confidential.

I understand and agree with the exchange of information with Job Connect partners for the purpose of scheduling, collaboration and job placement activities.

Section 504(A) of the Workforce Investment Act of 1998; Section 12c of the Rehabilitation Act of 1973 as Amended; 29USC711c and 721(a)(6)(A); 34CFR361.38; NRS 426.573,426.610,432B.220,615.280,615.290;629.061

**INACCURATE OR MISLEADING INFORMATION**

If you believe that information in your record of services is inaccurate or misleading, you may request that the Bureau of Vocational Rehabilitation amend the information. If the information is not amended, the request for an amendment must be documented in the record of services.

**LIABILITY OF STATE FOR THIRD PARTY ACTIONS**

The state of Nevada, Nevada Department of Employment, Training & Rehabilitation, the Rehabilitation Division and the Bureau of Vocational Rehabilitation and their officers, agents, employees and elected and appointed officials are not responsible in any manner for damages caused to a client by third-parties, including, but not limited to vendors on an approved list maintained by the State of Nevada, Nevada Department of Employment, Training & Rehabilitation, the Rehabilitation Division and the Bureau of Vocational Rehabilitation and hereby specifically disclaim any liability therefore. In addition, the State of Nevada will not waive and intends to assert available NRS chapter 41 liability in all cases.

**PRIOR AUTHORIZATION STATEMENT**

I understand the Bureau of Vocational Rehabilitation will not pay for any service which my counselor HAS NOT AUTHORIZED IN WRITING. If my counselor approves a medical examination, this is NOT approval for treatment or surgery.

When a doctor, hospital, merchant or other vendor has not received advance approval from my counselor, I understand I may have to pay for any goods or services myself.

**CLIENT FINANCIAL PARTICIPATION**

I understand that I will be asked to furnish financial information and my financial needs will be considered in determining my participation in the cost of those vocational rehabilitation services which require the expenditure of case service dollars. I will not be required to participate in the cost of diagnostic services to evaluate my rehabilitation potential, counseling guidance and referral services, or placement services.

**THE CLIENT ASSISTANCE PROGRAM (CAP)**

The CAP can provide you information and assistance regarding the programs and services offered by the Bureau. CAP can explain available services, investigate any concerns you may have and assist you to resolve your concerns. You may phone the Client Assistant at (702) 486-6688 or at the toll free number, 1-800-633-9879; or e-mail CAPS at DETRCAP@NVDETR.org

**REVIEW OF DISAGREEMENTS REGARDING THE FURNISHING OR DENIAL OF SERVICES**

If you disagree with a decision made by your rehabilitation counselor concerning the furnishing or denial of services, you have the right to have that decision reviewed. First, you should talk to your counselor or the counselor's supervisor about your concerns. Next, you can contact the CAP to assist you with the review process. You have the right to request a formal review of your dissatisfaction with the decision regarding the furnishing or denial of services. The review will be conducted by an impartial hearing officer. You must request a hearing in writing. You must state in your request the action(s) with which you are dissatisfied. You must send your written request to the Chief of the Bureau of Vocational Rehabilitation 1370 S Curry Street, Carson City, NV 89703.

**I HAVE BEEN ADVISED OF THE PROTECTION, USE AND RELEASE OF PERSONAL INFORMATION. I HAVE BEEN ADVISED OF THE CLIENT ASSISTANCE PROGRAM. I HAVE BEEN ADVISED OF MY OPPORTUNITY FOR REVIEW OF DECISIONS MADE BY MY REHABILITATION COUNSELOR REGARDING THE FURNISHING OR DENIAL OF SERVICES.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of person who filled out the form if different from applicant.

APPLICATION FOR VOCATIONAL REHABILITATION SERVICES (continued)  
**Identification Documentation**

In addition to the completed application, you will need to bring the following identification to your first appointment:

One (1) item from **List A** or one (1) item from **List B** and one (1) item from **List C**.

**List A**

1. UNITED STATES PASSPORT
2. CERTIFICATE OF UNITED STATES CITIZENSHIP
3. CERTIFICATE OF NATURALIZATION
4. UNEXPIRED FOREIGN PASSPORT WITH ATTACHED EMPLOYMENT AUTHORIZATION
5. ALIEN REGISTRATION CARD WITH PHOTOGRAPH

**List B**

1. A STATE ISSUED DRIVER'S LICENSE OR A STATE I.D. CARD WITH PICTURE OR INFORMATION INCLUDING NAME, SEX, DATE OF BIRTH, HEIGHT, WEIGHT AND COLOR OF EYES.
2. U.S. MILITARY I.D. CARD

**List C**

1. ORIGINAL SOCIAL SECURITY NUMBER CARD
2. A BIRTH CERTIFICATE ISSUED BY STATE, COUNTY OR MUNICIPAL AUTHORITY
3. UNEXPIRED INS EMPLOYMENT AUTHORIZATION

**HEALTH SURVEY**

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  M  F

This health survey, which is to be completed by you, will give your counselor an overview of your current health and mental background. Please provide as much detail as is possible on the form. You can write in the remarks section and on the back of the form.

1. What are your present symptoms or health problems? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. What treatment, including medications, do you now receive for your health problems or other symptoms?  
\_\_\_\_\_  
\_\_\_\_\_
3. How do your current symptoms or health problems limit what you can do around the home or on the job?  
\_\_\_\_\_  
\_\_\_\_\_
4. What is the name and address of your family doctor, or the doctor who last saw you? \_\_\_\_\_  
\_\_\_\_\_
5. What was the date of your last visit to the doctor? \_\_\_\_\_

APPLICATION FOR VOCATIONAL REHABILITATION SERVICES (continued)  
**HEALTH SURVEY** (continued)

Name: \_\_\_\_\_

6. List previous hospitalizations:

<u>Hospital</u>	<u>Date</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Check any of the following which are now or have been a health problem for you.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Back trouble                  | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Breathing problems            | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Vision problems  |
| <input type="checkbox"/> Bladder or kidney trouble     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Emotional or nervous trouble  | <input type="checkbox"/> Female problems     | <input type="checkbox"/> Dental problems  |
| <input type="checkbox"/> Stomach or intestinal trouble |  |   |

Other: \_\_\_\_\_

8. If employed, how many days of work have you lost in the past year due to illness? \_\_\_\_\_

9. Please indicate how much of the following you use **per day** (cups, 1 pack, beer, hard liquor, wine):

Tobacco: \_\_\_\_\_

Alcohol: \_\_\_\_\_

10. If you wish to describe any of the health problems more completely, please use the space below: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Applicant's Signature

If filled out by someone other than the applicant, sign below.

Relationship:

- |                                 |                                   |   |
|---------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Relative | <input type="checkbox"/> Representative |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Other    |   |

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