



State of Rhode Island
Department of Human Services
Office of Rehabilitation Services

40 Fountain Street ~ Providence, RI 02903
401-421-7005 ~ 401-222-3574 FAX ~ RI Relay - 711 ~ Spanish 401-462-7791
www.ors.ri.gov

"Helping individuals with disabilities to choose, find and keep employment"

Application and Initial Information for the Vocational Rehabilitation (VR) Program

Please fill out this application to the best of your ability. If you do not feel comfortable disclosing some of the information, you can complete the application when you meet with an ORS Counselor.

Legal Name: Preferred Name (if different):

Address: City/State/Zip:

Phone number: Cell/Video Relay:

Date of Birth: Veteran: Yes No E-mail Address:

Gender Identity: Preferred Pronouns:

Social Security Number: Emergency Contact:

Have You Previously Applied for VR Services? Yes No Previous Name:

What is your disability?

What is your employment or career goal(s)?

How did you learn about VR? Who referred you?

Do you receive? SSI SSDI (Attach award letter, if available) Did you receive a Ticket to Work? Yes No

What transportation is available to you? Car Bus Other Do you have a Drivers License? Yes No

Active? Yes No What state? What type? (CDL, regular, learners permit, restricted)

If restricted, describe:

Marital Status: Single Married Widowed Divorced Separated

Race: (Check all that apply) White Black/African American Asian

Native Hawaiian/Pacific Islander American Indian/Alaskan Native Hispanic/Latino

Do you speak English? Yes No If no, what is the primary language spoken?

Have you currently been unemployed for more than 27 consecutive weeks? Yes No

Do you want to register to vote? Yes No Have you ever been convicted of a felony? Yes No

I am applying for Vocational Rehabilitation Services because I want to work or maintain employment.

Signature: Date:

Parent or Guardian (if applicable) Date:

Counselor receipt of application (ORS personnel only):

Your assistance in providing the information requested on the following pages will help speed up your eligibility and employment plan process. A Vocational Rehabilitation Representative can assist you in completing the information if you wish. Please contact (401) 421-7005 (Intake) or RI Relay at 711, if you need assistance to complete the form, En Espanol, (401) 462-7791

WORK HISTORY (Most recent job and attach resume)

Employer Name and Address: _____

How did you get this job? _____

Hours per Week: _____ Dates Employed: _____ - _____ Hourly Pay: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason for Leaving Job: _____

EDUCATION & TRAINING

High School: _____ Highest Grade Completed: _____ Diploma: Yes No Date: _____

Special Education Certification of Completion: Yes No GED: Yes No Date: _____

Special Education [IEP/504]: Yes No

Support Services provided: (example: technology, aide, etc.) _____

College: _____ Years Attended: _____ Degree Obtained: _____

Other Skills/Trainings: _____

Certification(s) Obtained: _____ Date: _____

DISABILITY / MEDICAL CONDITION (What prevents you from working?)

Describe your limitations to employment: _____

Technology/Supports/Resources needed to work: _____

PHYSICIANS / HOSPITAL / MENTAL HEALTH / PSYCHOLOGIST / SOCIAL WORKER

PHYSICIANS/HOSPITAL/CLINIC	Specialty	Dates Of Service

MEDICATIONS/TREATMENTS	Name/Type	Dosage/Frequency



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CURRENT HEALTH AND FUNCTIONAL CAPACITIES SELF-ASSESSMENT

Please check the boxes that best fit

	AVERAGE	SOME PROBLEMS	COMMENTS
Using Transportation	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Speaking/Conversing	<input type="checkbox"/>	<input type="checkbox"/>	
Reading	<input type="checkbox"/>	<input type="checkbox"/>	
Writing	<input type="checkbox"/>	<input type="checkbox"/>	
Mood/Attitude	<input type="checkbox"/>	<input type="checkbox"/>	
Stress	<input type="checkbox"/>	<input type="checkbox"/>	
Getting Along with Others	<input type="checkbox"/>	<input type="checkbox"/>	
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	
Remembering	<input type="checkbox"/>	<input type="checkbox"/>	
Daily Life Routine	<input type="checkbox"/>	<input type="checkbox"/>	
Taking Medication	<input type="checkbox"/>	<input type="checkbox"/>	
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	
Making Decisions	<input type="checkbox"/>	<input type="checkbox"/>	
Learning New Tasks	<input type="checkbox"/>	<input type="checkbox"/>	
Planning/Setting Goals	<input type="checkbox"/>	<input type="checkbox"/>	
Accepting Direction	<input type="checkbox"/>	<input type="checkbox"/>	
Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	
Getting/Keeping a Job	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting/Standing	<input type="checkbox"/>	<input type="checkbox"/>	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting/Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	
Gripping/Holding Feeling	<input type="checkbox"/>	<input type="checkbox"/>	
Balance/Coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue/Stamina	<input type="checkbox"/>	<input type="checkbox"/>	
Breathing/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have any other barriers to employment not listed above? _____

Have you been hospitalized in the last two years? _____

Do you use? Tobacco Alcohol Drugs If yes, how much? _____

Do you have a history of dependency on? Alcohol Drugs Sobriety Date: _____

In planning for work, are you concerned with the loss of SSI/SSDI benefits? _____

This is the best estimate of my abilities and limitations.

Signature

Date