

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 <input type="checkbox"/> Male <input type="checkbox"/> 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 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: (Check Box) Married Widowed Divorced Separated Never Married	
I hereby apply for rehabilitation services: Date _____			Signature of applicant, parent, or legal guardian.		
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)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you now receiving services from one or more agencies? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any assistive devices or aids?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a citizen of the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a NYS driver's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, are you legally permitted to work in this country? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a driver's license from a state other than New York?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Check the benefits you now receive:	
Do you have Access to a motor vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Workers Compensation	
Do you use public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other, specify _____	
Are you able to leave your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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) _____

List the highest grade you have successfully completed: _____
 and check the applicable box(es)
 GED or High School 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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