

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: Best time to call DATE OF BIRTH
Race/Ethnicity-Choose ALL that apply. If left blank ACCES will complete. If Hispanic or Latino is checked, please check additional box.
What is your disability? Who referred you to us? MARITAL STATUS: (Circle Response)
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

Are you a veteran? Yes No

Do you use any assistive devices or aids? Yes No

Are you a citizen of the United States? Yes No

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

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

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

Check the benefits you now receive?

Do you have access to a motor vehicle? Yes No

SSI SSDI Workers Compensation

Do you use public transportation? Yes No

Other, specify _____

Are you able to leave your home? Yes 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) _____

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.

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