|  |  |
| --- | --- |
| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Application for Services**   |
| Initial Contact Information    |
| First contact date:       | Initial contact without case assignment date:       |
| Social Security number:      | Initial contact with case assignment date:      |
| Last name:      | First name:      | Middle Name:      |
| Prefix:       | Preferred Name:      | Date of birth:       |
| Homeless/Runaway  : [ ]  Individual does not meet the definition of homeless [ ]  Individual does meet the definition of homeless [ ]  Participant did not self-identify |
| Address:       | ZIP:       | ZIP suffix:      | State:   |
| City:      | County:      |
| Local Workforce Development Area:      |
| Primary Phone: (     )       Ext:       | Type:      Carrier:       | Phone 2: (     )       Ext:       | Type:      Carrier:       |
| Phone 3: (     )       Ext:       | Type:      Carrier:       | Phone 4: (     )       Ext:       | Type:      Carrier:       |
| Preferred Primary Method of Meeting: [ ]  Face to Face [ ]  Phone [ ]  Virtual[ ]  Did not Select/Disclose [ ]  Not Applicable  | Preferred Secondary Method of Meeting:[ ]  Face to Face [ ]  Phone [ ]  Virtual[ ]  Did not Select/Disclose [ ]  Not Applicable |
| Preferred Tertiary Method of Meeting:[ ]  Face to Face [ ]  Phone [ ]  Virtual[ ]  Did not Select/Disclose [ ]  Not Applicable | Preferred Method of Ongoing Contact:[ ]  Email [ ]  Text [ ]  Phone [ ]  Mail |
| Customer has Internet: [ ]  Yes [ ]  NoCustomer has computer/laptop: [ ]  Yes [ ]  NoCustomer is able to video conference: [ ]  Yes [ ]  No |
| Video Relay IP Address:       |
| Primary Email 1:      Type:       | Email 2:     Type:       |
| Email 3:     Type:       | Email 4:     Type:       |
| Other:       |
| Currently Enrolled   : [ ]  Not at this time [ ]  Grades 7-12 [ ]  Private School 7-12 [ ]  Home School 7-12 [ ]  Grades K-6 [ ]  Private School K-6 [ ]  Home School K-6 [ ]  18+ Program in High School [ ]  GED Program [ ]  College 2 year [ ]  College 4 year [ ]  Grad school- Master’s degree [ ]  Grad school- PhD [ ]  Vocational school for industry certification [ ]  Vocational Training not leading to a credential [ ]  Training-DOL Registered Apprenticeship |
| Individualized Education Plan: [ ]  Yes [ ]  No [ ]  Did not disclose |
| 504 Plan: [ ]  Yes [ ]  No [ ]  Did not disclose |
| Level of Education at Initial Contact:       |
| Disaster/Incident Victim: [ ]  Yes [ ]  No[ ]  COVID-19 Job Loss [ ]  COVID-10 VR/OIB Service Delay [ ]  Winter Storm 2021 [ ]  Mass Incident at Robb Elementary-Uvalde |
| Population Indicators : [ ]  Acquired brain injury (including TBI and Stroke) [ ]  Blind Vocational Rehabilitation [ ]  Deaf/Hard of Hearing [ ]  Deafblind [ ]  Independent Living Services for Older Individuals who are Blind (OIB) [ ]  Mobility Impaired [ ]  Mental Health/Substance Abuse [ ]  General Vocational Rehabilitation [ ]  Neurodevelopmental [ ]  Recipient of Subminimum Wages from a 14c [ ]  Spinal Cord Injury (SCI) [ ]  Veteran [ ]  VRS Transition |
| Race and Ethnicity  : [ ]  American Indian or Alaska Native [ ]  Asian [ ]  Black or African American [ ]  Hispanic or Latino [ ]  Native Hawaiian or other Pacific Islander [ ]  White [ ]  Did not self-identify (this option is not available for those 18 or younger) |
| Certified Degree of Indian Blood Card: [ ]  Yes [ ]  NoIf yes, Indian and Native American Programs:       |
| VR Services Strategy Requested  : [ ]  Preparing for Employment [ ]  Obtaining Employment [ ]  Retaining Employment [ ]  Advancing Employment [ ]  Exploring Older Blind Services [ ]  Pre-ETS Services Only [ ]  Older Blind Services Only [ ]  Career Counseling for 511 Customers Only |
| Anticipated Employment Outcome  : [ ]  Competitive Integrated Employment [ ]  Self-Employment[ ]  Supported Employment [ ]  Supported Self-Employment |
| How may we help you?:       |
| Referral Source   |
| Referral Category : [ ]  Education Institutions-Public or Private [ ]  Public Agencies and Organizations[ ]  Private Organizations and Individuals [ ]  Hospitals and Health Organizations-Public or Private  |
| Referral Source:       |
| Referral Source Name:       |
| Referral Source Address:      | ZIP:       | State:       |
| City:       | County:       |
| Referral Source Phone Number: (     )        | Ext:      | Type:      |
| Start My VR Ticket Number:       |
| Personal  Information  |
| Do not contact for Surveys [ ]  |  |
| Gender: [ ]  Female [ ]  Male [ ]  Did not self-identify | Marital status:       |
| Living arrangements:       | Job Ready: [ ]  Yes [ ]  No |
| Driver’s license or state ID number:       | State:       |
| Language Preference:       | English Language Learner:       |
| Media Preference:       |
| Customer may need assistive or rehabilitative technology [ ]  Yes [ ]  No |
| Lawsuit Pending: [ ]  Yes [ ]  No  |
| Customer has barriers related to an arrest, conviction, or other offense or delinquent act: [ ]  Did not disclose [ ]  No [ ]  Yes  | Housed in a jail or prison at application: [ ]  Yes [ ]  NoIf applicable, date released from incarceration:        |
| Offered Voter Registration Assistance to the Customer Date (Reference VR1680):        |
| Immigration    |
| Is the customer a U.S. citizen? | [ ]  Yes [ ]  No |
| Is the customer an immigrant alien? | [ ]  Yes [ ]  No |
| Does the customer have a work permit? | [ ]  Yes [ ]  No |
| **I9 Verification** |
| Document List Type (List A, B and/or C):       |
| Document(s) Provided:       |
| Does Document(s) provided have an Expiration Date: [ ]  Yes [ ]  NoIf yes, Expiration Date:       |
| Inactivate Document Provided:       |
| Reason Document Inactivated:       |
| Insurance    |
| [ ]  No insurance[ ]  Medicaid[ ]  Medicare[ ]  Private insurance through own employment[ ]  Private Insurance available through employer is pending[ ]  Private insurance through other means[ ]  CHIP[ ]  Texas Healthy Kids[ ]  Children with Special Health Care Needs (CSHCN)[ ]  Public insurance through federal means[ ]  Public insurance through other means |
| Medicaid Status    |
| Medicaid number:      | Verification source and status:      | Verification date:      |
| Employment    |
| Status (select one):  [ ]  Competitive Integrated Employment[ ]  Self-Employed[ ]  Randolph-Sheppard Business Enterprise Program[ ]  Employed: State Agency-managed Business Enterprise Program[ ]  Employed: Extended Employment[ ]  Employed but Termination Notice Received[ ]  Employed: Transitioning Service Member[ ]  Not Employed: Student in Secondary Education[ ]  Not Employed: All Other Students[ ]  Not Employed: Trainee, Intern or Volunteer[ ]  Not Employed: Other |
| Employed with No Earnings: [ ]  Yes [ ]  No |
| Employment Status Type: [ ]  Job Retention [ ]  Career Advancement [ ]  Not Applicable |
| Workers’ Compensation   |
| Is the customer seeking services due to an injury on the job?  [ ]  Yes [ ]  No |
| Does the customer have a current workers' compensation case that is, receiving either medical benefits or income benefits or both?  [ ]  Yes [ ]  NoIf yes, check all that apply below: [ ]  Texas Division of Workers’ Compensation[ ]  Federal Workers’ Compensation[ ]  Workers’ compensation agency other than Texas or federal |
| Employment Status Case Note (Not Working)  |
| Have you ever worked?  | [ ]  Yes [ ]  No |
| Has or will your disability interfere with your ability to get a job?  | [ ]  Yes [ ]  No |
| Have you lost a job due to your disability? | [ ]  Yes [ ]  No |
| Has or will your disability interfere with training or other preparation for a job?  | [ ]  Yes [ ]  No |
| Has or will your disability cause you to need special assistance to perform job duties?  | [ ]  Yes [ ]  No |
| What services do you need?       |
| Comments:       |
| Employment Status Case Note (Working)  |
| Are you in danger of losing your job because your disability prevents the performance of essential job functions? | [ ]  Yes [ ]  No |
| Do you need services, special assistance, or accommodations to keep your job? | [ ]  Yes [ ]  No |
| Do you think your current job is below your abilities? | [ ]  Yes [ ]  No |
| Is your disability interfering with maintaining your job?  | [ ]  Yes [ ]  No |
| What services do you need?       |
| Comments:       |
| **Insurance Policy**   |
| Insurance carrier 1:       |
| Policy number:       | Group number:      |
| Insurance carrier 2:       |
| Policy number:       | Group number:       |
| Insurance carrier 3:       |
| Policy number:       | Group number:       |
| **Veteran Information**   |
| Veteran Status[ ]  Did not Disclose[ ]  Veteran with Dishonorable Discharge[ ]  Veteran- Any discharge other than dishonorable discharge[ ]  Not a veteran |
| Active Military: [ ]  Yes [ ]  No |
| Military State Postal Code:       |
| Transitioning Service Member: [ ]  Yes [ ]  No  |
| Received VA Services: [ ]  Yes [ ]  No  |
| Eligible Veteran Status:       |
| Disabled Veteran: [ ]  Yes [ ]  No  |
| Date of Actual Military Separation:       |
| Work History Information   |
| **Has the customer ever been employed?** **[ ]  Yes** **[ ]  No If no, proceed to next section.** |
| Employer name 1:      |
| Hire date (month, day, and year):       |
| Occupation:       |
| End date (month, day and year):       |
| Number of Months Employed:       |
| Is this a Trial Work experience? [ ]  Yes [ ]  No |
| Trial Work type:       |
| Is Trial Work a success? [ ]  Yes [ ]  No |
| Reason for leaving:       |
| Employer address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone number: (     )       Ext:        | Type:       |
| Employer name 2: |
| Hire date (month, day, and year):       |
| Occupation:       |
| End date (month, day, and year):       |
| Number of Months Employed:       |
| Is this a Trial Work experience? [ ]  Yes [ ]  No |
| Trial Work type:       |
| Is Trial Work a success? [ ]  Yes [ ]  No |
| Reason for leaving:       |
| Employer address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone number: (     )       Ext:        | Type:       |
| Employer name 3: |
| Hire date (month, day, and year):       |
| Occupation:       |
| End date (month, day, and year):       |
| Number of Months Employed:       |
| Is this a Trial Work experience? [ ]  Yes [ ]  No |
| Trial Work type:       |
| Is Trial Work a success? [ ]  Yes [ ]  No |
| Reason for leaving:       |
| Employer address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone number: (     )       Ext:        | Type:       |
| Current Employment Information (complete only if employed at time of application)   |
| Job title:       |
| Earning type: [ ]  Weekly [ ]  Hourly [ ]  Bi-weekly [ ]  Monthly |
| Weekly hours worked:       | Gross weekly, hourly, bi-weekly, or monthly earnings:       |
| Hire date (month, day, and year):       |
| Employment end date:       | Is this Federal Employment: [ ]  Yes [ ]  No |
| Employer name:       |
| Employer address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone number: (     )       Ext:        | Type:       |
| Website URL:       | Email:       |
| Employer additional information or comments:       |
| Information source:       | Employer contact okay? [ ]  Yes [ ]  No |
| Employed with no earnings? [ ]  Yes [ ]  No |
| Monthly Financial Information    |
| [ ]  **Customer refused to disclose financial information.** |
| **Economic Resources** |
| Net Wages:       |
| Net Income if self-employed:       |
| Total Savings and Liquid Assets (includes savings, stocks, bonds etc. of the customer, spouse, and parent, if dependent):       |
| **Personal Income**    |
| Weekly hours worked:       |
| Gross weekly earnings: $      | Gross Bi-weekly earnings: $      |
| Hourly wage: $      | Gross monthly earnings: $      |
| Child support: $      | Interest, dividends, trusts and royalties: $      |
| Savings (enter monthly amount used from savings): $      | Rental income: $       |
| Pension or annuities: $      | Other customer income (other income not included in categories above): $       |
| **Public Support**    |
| Pell Gant Recipient: [ ]  Yes [ ]  No |
| TANF: $      | Exhausting TANF within two-years: [ ]  Yes [ ]  No |
| General Assistance (Include payments from State or Local government): $      | Workers’ Comp:       |
| Unemployment Compensation: $      | Veterans' Disability Benefit: $      |
| Other Public Support "cash benefit" not listed: $      | Non-cash support: $      |
| **Support from Family and Friends**    |
| Family and Friends Net Earnings (spouse/parent/guardian/children/friend including income, wages or public support or other sources): $      |
| Any In-Kind Non-Cash Support from Family and Friends: [ ]  Yes [ ]  No |
| **Support from Other Sources**    |
| Private Disability Insurance / Charities: $      |
| Any In-Kind or non-cash support from a charity: [ ]  Yes [ ]  No |
| **Adjustments to Income**    |
| Mortgage/Rent: $      | Other Expenses (include medical or court related) $      |
| Government garnishment: $      | Child Support garnishment: $      |
| **Allowances**    |
| Number of Dependents (number of individuals who are dependent upon the customer's and/or family's income and liquid assets.):       |
| Reason for Update:      |
| Social Security Income Benefits  |
| Supplemental Income Security Benefits (SSI)- Presumptive Eligibility for VR Services  |
| Do you receive SSI Disabled/Blind Adult benefits: [ ]  Yes [ ]  No |
| Do you receive 1619b Medicaid: [ ]  Yes [ ]  No |
| Do you receive SSI Childhood benefits: [ ]  Yes [ ]  No |
| Title II Disability Benefits- Presumptive Eligibility for VR Services  |
| Do you receive Title II Social Security Disability Insurance benefits: [ ]  Yes [ ]  No |
| Do you receive Title II Childhood Disability Beneficiary/Disabled Adult benefits: [ ]  Yes [ ]  No  |
| Do you receive Title II Disabled Widow/Widower benefits: [ ]  Yes [ ]  No |
| Overpayment  |
| Do you have an overpayment from an SSI benefit: [ ]  Yes [ ]  No |
| Do you have an overpayment from a Title II disability benefit: [ ]  Yes [ ]  No |
| Are you paying a monthly amount to Social Security at time: [ ]  Yes [ ]  No |
| Other Social Security Benefits- NOT presumptively eligible for VR services  |
| Do you receive SSI Aged Adult benefits: [ ]  Yes [ ]  No |
| Do you receive Title II Cash benefits (youth under age 18 only): [ ]  Yes [ ]  No |
| Do you receive Social Security Retirement benefits: [ ]  Yes [ ]  No |
| Ticket to Work  |
| Do you have a ticket to work: [ ]  Yes [ ]  No |
| Are you working with a provider to find employment: [ ]  Yes [ ]  No |
| Provider Name:       |
| Provider Contact:       |
| Information Request    |
| **Source name 1:** | **From date:**      | **To date:**      |
| Address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone 1: (     )       Ext:       | Type:      | Phone 2: (     )       Ext:       | Type:      |
| Phone 3: (     )       Ext:       | Type:      | Phone 4: (     )       Ext:       | Type:      |
| Source Email:       |
| Source Website:       |
| Comments:       |
| **Source name 2:**      | **From date:**      | **To date:**      |
| Address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone1: (     )       Ext:       | Type:      | Phone 2: (     )       Ext:       | Type:      |
| Phone 3: (     )       Ext:       | Type:      | Phone 4: (     )       Ext:       | Type:      |
| Source Email:       |
| Source Website:       |
| Comments:       |
| **Source name 3:** | **From date:**       | **To date:**       |
| Address:       | ZIP:      | State:   |
| City:      | County:      |
| Phone 1: (     )       Ext:       | Type:      | Phone 2: (     )       Ext:       | Type:      |
| Phone 3: (     )       Ext:       | Type:      | Phone 4: (     )       Ext:       | Type:      |
| Source Email:       |
| Source Website:       |
| Comments:       |
|  **Application Statement**   |
| I, the applicant, confirm that I:* understand that I am applying for vocational rehabilitation services leading to an employment outcome;
* understand that Texas law requires that all financial information I provide to the agency must be complete and accurate;
* agree to participate in all evaluations that are necessary to determine my eligibility for services;
* have received copies of the program brochures that include information about agency application process, appeals process, mediation procedures, and the availability of the Client Assistance Program;
* understand that the agency has the right to pursue reimbursement for services purchased for me if I receive a judgment or insurance settlement as a result of a lawsuit, claim, or other legal action related to my disability; and
* understand that my Ticket to Work will be assigned to the agency.
 |
| **Signatures** |
| Applicant’s signature:**X**    | Applicant’s name:       | Date:      |
| Parent’s, guardian’s, and/or representative’s signature (if applicable):**X**    | Parent’s, guardian’s, and/or representative’s name (if applicable):       | Date:      |
| VR representative’s signature:**X**   | VR representative’s name:      | Date:      |
| Witness’s signature (if one of the above signs with mark):**X**   | Witness’s name (if one of the above signs with a mark):      | Date:       |