



**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    No Customer has computer/laptop:    Yes    No Customer 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: <input type="checkbox"/> Acquired brain injury (including TBI and Stroke) <input type="checkbox"/> Blind Vocational Rehabilitation <input type="checkbox"/> Deaf/Hard of Hearing <input type="checkbox"/> Deafblind <input type="checkbox"/> Independent Living Services for Older Individuals who are Blind (OIB) <input type="checkbox"/> Mobility Impaired <input type="checkbox"/> Mental Health/Substance Abuse <input type="checkbox"/> General Vocational Rehabilitation <input type="checkbox"/> Neurodevelopmental <input type="checkbox"/> Recipient of Subminimum Wages from a 14c <input type="checkbox"/> Spinal Cord Injury (SCI) <input type="checkbox"/> Veteran <input type="checkbox"/> 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    No If 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

Sex: Female Male Prefer not to answer/Did not disclose

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 No  
If 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        No

If 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      No

If 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
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Has or will your disability interfere with your ability to get a job?	Yes	No
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Have you lost a job due to your disability?	Yes	No
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Has or will your disability interfere with training or other preparation for a job?	Yes	No
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Has or will your disability cause you to need special assistance to perform job duties?	Yes	No
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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
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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
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What services do you need?

Comments:

### Insurance Policy

Insurance carrier 1:

Policy number:	Group number:
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Insurance carrier 2:

Policy number:	Group number:
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Insurance carrier 3:

Policy number:		Group number:	
<b>Veteran Information</b>			
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:			
<b>Work History Information</b>			
<b>Has the customer ever been employed?    Yes    No    If no, proceed to next section.</b>			
<b>Employer name 1:</b>			
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:	
<b>Employer name 2:</b>			
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:	
<b>Employer name 3:</b>			
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:	
<b>Current Employment Information (complete only if employed at time of application)</b>			
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		
<b>Monthly Financial Information</b>		
<input type="checkbox"/> <b>Customer refused to disclose financial information.</b>		
<b>Economic Resources</b>		
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):		
<b>Personal Income</b>		
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): \$	
<b>Public Support</b>		
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: \$
<b>Support from Family and Friends</b>	
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	
<b>Support from Other Sources</b>	
Private Disability Insurance / Charities: \$	
Any In-Kind or non-cash support from a charity:      Yes      No	
<b>Adjustments to Income</b>	
Mortgage/Rent: \$	Other Expenses (include medical or court related) \$
Government garnishment: \$	Child Support garnishment: \$
<b>Allowances</b>	
Number of Dependents (number of individuals who are dependent upon the customer's and/or family's income and liquid assets.):	
Reason for Update:	
<b>Social Security Income Benefits</b>	
<b>Supplemental Income Security Benefits (SSI)- Presumptive Eligibility for VR Services</b>	
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	
<b>Title II Disability Benefits- Presumptive Eligibility for VR Services</b>	
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	
<b>Overpayment</b>	
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	
<b>Other Social Security Benefits- NOT presumptively eligible for VR services</b>	
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	
<b>Ticket to Work</b>	

Do you have a ticket to work:    Yes    No			
Are you working with a provider to find employment:    Yes    No			
Provider Name:			
Provider Contact:			
<b>Information Request</b>			
<b>Source name 1:</b>		<b>From date:</b>	<b>To date:</b>
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:			
<b>Source name 2:</b>		<b>From date:</b>	<b>To date:</b>
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:			
<b>Source name 3:</b>		<b>From date:</b>	<b>To date:</b>

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:			