



PLEASE PRINT

Name (Last)		First	M.I.	Suffix (e.g., Jr.)	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date (mm/dd/yyyy)		County of Residence	
Home Address (Street)			City	State	Zip Code
Home Phone No.	Alternate Phone No.	E-mail Address			
Race/ethnicity:					
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Hispanic/Latino			
<input type="checkbox"/> Asian		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander			
<input type="checkbox"/> Black/African-American		<input type="checkbox"/> White			
Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please list your immigration status:					
Contact person(s): If you complete this section, you are permitting OOD to disclose to the individual that you have applied for services.					
Name		Address (Street, City, State, Zip)		Phone No.	
Where do you live?					
<input type="checkbox"/> Assisted Living Center		<input type="checkbox"/> Halfway House		<input type="checkbox"/> Nursing Home	
<input type="checkbox"/> Community Residential/Group Home		<input type="checkbox"/> Homeless/Shelter		<input type="checkbox"/> Private Residence	
<input type="checkbox"/> Correctional Institution, Adult		<input type="checkbox"/> Independent Mental Health Facility		<input type="checkbox"/> Rehabilitation Facility	
<input type="checkbox"/> Dependent with Family and Friends		<input type="checkbox"/> Not Available		<input type="checkbox"/> Substance Abuse Treatment Ctr	
				<input type="checkbox"/> Other (Indicate)	
Would you like to register to vote? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already registered <input type="checkbox"/> Not Eligible					
Are you referring yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who is referral source?					

How do you financially support yourself?

- Personal income
- Family and friends
- Public support (Click all that apply):
 - SSI, SSDI, TANF, Food stamps
- Other sources, List:

Which types of medical insurance do you receive?

- Click all that apply.
- Medicaid Medicare Public through Other Sources
 - Private Ins, through Own Employment
 - Private Ins, through Other Means
 - None Not Available

What is your highest grade completed?

- No formal Schooling
- Elementary education (1-8)
- Secondary education (9-12), no high school diploma
- Special Ed.(completion or attendance)

- High school graduate or equivalency (Reg GED)
- Post-secondary education, no degree
- Associate degree or voc/tech cert
- Bachelor's degree
- Master's degree or higher

Have you ever received services under an individualized education plan (IEP)? Yes No

Are you currently working? Yes No **What is your hourly wage?**
How many hours per week?

Are you currently enrolled in high school? Yes No

Are you a Veteran? Yes No

What is your disability?

This application will be considered complete when it is initialed and dated by VR Staff or VR Contractor at the time of your appointment.

The State of Ohio is committed to good privacy practices. As such, we are disclosing that in order to fully process your application, verify your eligibility and provide vocational rehabilitation services, the Opportunities for Ohioans with Disabilities (OOD) may need to access personal information about you, such as your Social Security Number, which is maintained by the OOD. By signing this application, you are requesting that OOD access any personal information necessary to process your application, determine eligibility and provide services. Please note that OOD will continue to protect any non-public, confidential personal information maintained about you from release to the public or unauthorized third parties.

OOD does not discriminate against any applicant for services on the basis of race, color, religion, national origin/ancestry, disability, age (40 years or older), sexual orientation, gender or sex, veteran or military status, and/or genetic information or in any manner prohibited by law.

I acknowledge that in applying for services, OOD may obtain or release confidential personal information about me as follows:

- to purchase services for me;
- In collaboration with OOD Contractors and Partners on my behalf;
- to report my progress to the agency who referred me to OOD;
- when required by law and to facilitate the administration of the Rehabilitation Act;
- to do research to improve the lives of people with disabilities;
- to the Social Security Administration (SSA) and/or Division of Disability Determination (DDD) when I am applying for or am a recipient of SSDI or SSI benefits; and
- to other state agencies, if applicable.

Signature of Applicant (If under 18, parent/guardian must also sign below)

Date

Signature of Parent or Guardian

Date

OOD Use Only: I have explained OOD services and procedures, the applicant's rights, confidentiality, the Client Assistance Program (CAP), and the right to register to vote. I have provided the applicant the VR Application Fact Sheet about rights, duties and informed choice. I have also provided a copy of this application in the preferred mode of communication of this applicant. I certify that this application is accurate. **Initials** _____ **Date** _____

How was this form received? Electronically In Person Mail Phone Other:

Original – Counselor

Copy – Consumer