Please return the completed form to:

Please print or type all entries

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 (8/11)

NAME *Last*	*First*	*Middle Initial*	**GENDER** ☐ Male ☐ Female
If your school, health, or any other records are listed under another name, then enter the name(s) here:	*Last*	*First*	*Middle initial*
MAILING ADDRESS *Street*			*Apartment Number*
City	*State*	*ZIP + 4 Code*	*County*

SOCIAL SECURITY NUMBER

PHONE NUMBER(s) *where we can reach you or leave a message*	*Best time to call*	**DATE OF BIRTH**
1. ( ) *Area Code* **2. ( )** *Area Code*	**1.** **2.**	**Month Day Year**
Email : _____		

Race/Ethnicity – Choose ALL that apply. If left blank ACCES will complete. If Hispanic or Latino is checked please check additional box.	☐ American Indian or Alaska Native ☐ Asian (Includes Indian Subcontinent) ☐ Black or African American	☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

What is your disability?	**Who referred you to us?**	**MARITAL STATUS** ☐	**1** Married **2** Widowed **3** Divorced **4** Separated **5** Never Married

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. • • •

While you do *not have to answer* these questions now, 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 are, indicate the name(s) and address(es) _____

_____

Describe how your disability limits your ability to work.

What services are you seeking from ACCES-VR?

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.

Are you disabled because of a work-related injury? ☐ Yes ☐ No	Check the ☐ SSI ☐ SSDI
Do you use any assistive devices or aids? ☐ Yes ☐ No	benefit(s) you ☐ Workers ☐ Other *now* receive Compensation
Do you have a valid driver's license? ☐ Yes ☐ No	Do you regularly see a doctor or clinic about your disability? ☐ Yes No ☐
Do you have access to a motor vehicle? ☐ Yes ☐ No	If 'Yes,' indicate date of last visit _____
Do you use public transportation? ☐ Yes ☐ No	Also, if you see *one or more* doctors or clinics about your disability, list in the box below their names and addresses.
Are you able to leave your home? ☐ Yes ☐ No	
Name and address of doctor(s) and clinic(s)	

***Circle* the highest grade you have successfully completed, and check the applicable box(es)**

1 2 3 4 5 6 7 8 Elementary **9 10 11 12 High School** **GED, or High School Equivalency Diploma** ☐ Yes ☐ No **13 14 15 16 College** **17 One or More Years in 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

List below other people in your household

Full Name	Age	Their Relationship to You

List below the person or persons ACCES-VR can contact in an emergency

Name	Address	Phone

List below your work history (include attachments, as necessary)

Employer Name and Address	Date Employed From	Date Employed To	Weekly Earnings	Job title and duties, and Reason for Leaving

All information will be kept confidential and is subject to verification