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

Please print or type all entries

NAME       Last               First                Middle initial       GENDER

If your school, health, or any other records are listed under another name, then enter the name(s) here:

MAILING ADDRESS

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

PHONE NUMBER(s) where we can reach you or leave a message
1. (             ) 2. (             )

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
Hispanic or Latino
Asian (Includes Indian Subcontinent)
Native Hawaiian or Other Pacific Islander
Black or African American
White

What is your disability?

Who referred you to us?

MARITAL STATUS

1 Married 3 Divorced
2 Widowed 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)?

Are you now receiving services from one or more agencies?

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?
Are you disabled because of a work-related injury?  □ Yes  □ No

Do you use any assistive devices or aids?  □ Yes  □ No

Do you have a valid driver’s license?  □ Yes  □ No

Do you have access to a motor vehicle?  □ Yes  □ No

Do you use public transportation?  □ Yes  □ No

Are you able to leave your home?  □ Yes  □ No

Check the □ SSI □ SSDI benefit(s) you now receive

Do you regularly see a doctor or clinic about your disability? □ Yes  □ No

If ‘Yes,’ indicate date of last visit ______

Also, if you see one or more doctors or clinics about your disability, list in the box below their names and addresses.

Name and address of doctor(s) and clinic(s)

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

<table>
<thead>
<tr>
<th>1 2 3 4 5 6 7 8 9 10 11 12</th>
<th>Elementary</th>
<th>GED, or High School Equivalency Diploma</th>
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<tbody>
<tr>
<td>13 14 15 16 17 20</td>
<td>College</td>
<td>One or More Years in Graduate School</td>
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</table>

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

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**List below other people in your household**

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Age</th>
<th>Their Relationship to You</th>
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**List below the person or persons ACCES-VR can contact in an emergency**

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<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
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**List below your work history (include attachments, as necessary)**

<table>
<thead>
<tr>
<th>Employer Name and Address</th>
<th>Date Employed From</th>
<th>To</th>
<th>Weekly Earnings</th>
<th>Job title and duties, and Reason for Leaving</th>
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*All information will be kept confidential and is subject to verification*

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