WORK & EDUCATIONAL EXPERIENCE

WORK HISTORY (Most recent first or attach resume)

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____-_____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason for Leaving Job: _____

* * *

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____-_____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

* * *

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____-_____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

EDUCATION &TRAINING

Highest Grade Completed: ____ Special Education [IEP]: Y __ N __ Diploma: Y __ N __ GED: Y __ N __

Did you receive support services in school? Y __ N __ Describe (e.g. technology, aide, etc.): _____

_____

High School: _____ College: _____

Degree Obtained: _____ Year:_____

Other Training: _____

Skills/Hobbies (e.g. languages, computer, skills, licenses, volunteer experience, etc.): _____

_____

_____

INFORMATION ABOUT YOUR DISABILITY

DISABILITY/MEDICAL CONDITION (What prevents you from working?)

Describe your limitations to employment: _____
_____
_____
Medical condition (if known): _____

PHYSICIANS/HOSPITAL/CLINIC **Dates of Service**
Name(s) and Address: _____
_____
_____
_____

MENTAL HEALTH/PSYCHOLOGIST/SOCIAL WORKER **Dates of Service**
Name(s) and Address: _____
_____
_____
_____

MEDICATIONS/TREATMENTS **Name/Type** **Dosage/Frequency**
_____
_____
_____
_____
_____
_____

MEDICAID Y __ N __ **MEDICARE Y __ N __** **PRIVATE Y __ N __**

MEDICAL COVERAGE **Insurance/Benefit** **Claim No.** **Provided by Employer**
_____
_____

EQUIPMENT NEEDED TO WORK _____
_____
_____

COUNSELOR'S COMMENTS:_____
_____
_____
_____

DEMOGRAPHICS

Number of Persons in Household: _____ Number of Dependents: _____

Marital Status: Single __ Married __ Widowed __ Divorced __ Separated __

Check All That Apply: White __ Black/African American __ Asian __
Native Hawaiian/Pacific Islander __ American Indian/Alaskan Native __

Ethnicity (Check one): Hispanic/Latino Yes ___ No ___

PUBLIC BENEFITS/INCOME (Optional)

(A financial needs test must be completed for many VR-purchased services. The following income information will be helpful for your initial planning.)

Cash, Savings and Other Liquid Assets $_____

GROSS INCOME	Amount (Wk./Mo./Yr.)
Wages/Salary _____	$_____
Social Security Insurance (SSI) _____	$_____
Social Security Disability Insurance (SSDI) _____	$_____
Family Independence Program (FIP)/ RIWorks_____	$_____
Temporary Disability Insurance (TDI) _____	$_____
Workers Compensation _____	$_____
Veterans Benefits _____	$_____
Unemployment Benefits ____ _____	$_____
Private Disability Insurance _____	$_____
Pension or Annuity _____	$_____
Other Income_____	$_____

(Savings, including spousal income, rents, interest, etc.)

REHABILITATION EXPENSES (Non-Reimbursable)	**WEEKLY AMT.**
Medical _____	$_____
Rehabilitation/Adaptive Technology _____	$_____
Other Rehabilitation Needs _____	$_____

CERTIFICATION: (Complete once you have met with a VR Representative)

I have been provided with an explanation of the VR program, my rights and responsibilities, and I have been given a Client Assistance Program (CAP) brochure. I have been informed that I can appeal decisions, and I have been told how to do this. I have also been advised of the necessity to have all services pre-approved by my ORS Representative and to keep him/her informed of any changes in my situation whether, medical, financial, or otherwise. I certify that the information I give is true and complete to the best of my knowledge and belief, and I know that false or misleading statements or failure to report changes may result in prosecution for intent to defraud. I understand that the information given is CONFIDENTIAL, and it will be used only for purposes directly connected with the administration of the VR program.

I agree to notify my ORS Counselor when I become employed and allow ORS to access my wage records.

Signatures: _____ _____ _____

Applicant *Parent or Guardian (if applicable)* *Date*

Signature of Person who helped you complete application: _____Phone: _____

Vocational Rehabilitation Counselor: _____

DEPARTMENT OF HUMAN SERVICES – OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ (401) 421-7016 (TTY)
"Helping individuals with disabilities to choose, find and keep employment"

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. *(Name of Client)*

My Date of Birth: ____ / ____ / ____ My Social Security Number: _____ - _____ - _____

II. My information is to be disclosed to/ provided by:

_____
Name of
_____
Address
_____
City/ST/Zip

And is to be provided to/disclosed by:

Office of Rehabilitation Services
Name of
40 Fountain Street
Address
Providence, RI 02903
City/ST/Zip

III. The purpose or need for this release of information is:

❑ To obtain the information checked below that will assist me in vocational rehabilitation planning
❑ My own personal and private reasons
❑ Other (*specify*): _____

IV. The information to be disclosed from my health record: (*check all of the boxes that apply*)

❑ Vocational ❑Medical ❑Educational ❑Social
❑ Financial ❑ Psychiatric/Psychological ❑Other (*specify*): _____
❑ **Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

Specific Information Needed: _____

Dates of Service: _____ to _____

I would also like the following sensitive information disclosed: (*check the applicable box*(*es*))

❑ Alcohol/Drug Abuse Treatment/Referral ❑ HIV/AIDS-related Treatment
❑ Sexually Transmitted Diseases

V. I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me. _____*(Enter if different from one year after the date below)*

_____ _____
Signature of Client **Date**

_____ _____ _____
Signature of Authorized Representative **Relationship to the Client** **Date**

Instructions for Completing Form ORS-37

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.

2. Section I **–** print name of the client whose information is to be released.

3. Section II **–** print the name and address of the person or organization authorized to release and/or receive the information. Also, provide the name of the DHS/ORS representative, unit and address that will receive and/or release the information.

4. Section III **–** state the reason why the information is needed (e.g., disability claim, continuing medical care)

5. Section IV **–** check all of the boxes that apply.

    a. Vocational, Medical, Educational, Social, Financial, Psychiatric/Psychological

    b. Other *(specify)* – specific information identified by the client (e.g., billing, employee health)

    c. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

    Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

    d. Specific Information Needed – clearly identify the precise information to be disclosed.

    e. Dates of Service – note the first and last date of service requested.

    f. RELEASE OF SENSITIVE INFORMATION **–** check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases – patient must check the appropriate box!

6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V – Authorized Representative (e.g., parent, legal guardian, power of attorney)

8. A copy of the completed Form ORS-37 will be given to the client.

DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TTY)

"Helping individuals with disabilities to choose, find and keep employment"

CURRENT HEALTH AND FUNCTIONAL CAPACITIES SELF-ASSESSMENT

Name: _____ Date: _____

Height:_____ Weight: _____ D.O.B.: _____ SS#: _____

Please list the most important problem(s) that interfere with your working: _____

_____

For each area below, choose whether you have EXCELLENT or AVERAGE health or ability in that area or whether you have some problems. This is important information in planning for work.

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
HEARING				
SEEING				
SPEAKING				
SITTING				
STANDING				
WALKING				
KNEELING				
BENDING				
LIFTING				
PUSHING/PULLING				
HANDLING/FINGERING/FEELING				
CLIMBING				
BALANCING				
COORDINATION				
STRENGTH				
ENERGY/STAMINA				
BREATHING				
ALLERGIES				
REMEMBERING				
LEARNING				
READING				
WRITING				
CONCENTRATING				

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
MAKING DECISIONS				
SOLVING PROBLEMS				
GETTING ORGANIZED				
COLD/HOT WEATHER				
GROOMING/SELF CARE				
PEOPLE (GETTING ALONG WITH OTHERS)				
NERVOUSNESS/ANXIETY				
DEPRESSION				
MEALS/DIGESTION				
TAKING MEDICATIONS				
USING TRANSPORTATION				
USING ADAPTIVE EQUIPMENT				
JOB SKILLS				
HOW TO FIND AND GET JOBS				
WORK HABITS				
BEING RELIABLE/DEPENDABLE				
WORK RECORD				
OTHER (PLEASE LIST				

How often have you been hospitalized in the last two years? _____

Do you use? ( ) Tobacco ( ) Alcohol ( ) Other Drugs If yes, how much? _____

Do you have a history of dependency on ( ) Drugs ( ) Alcohol

If so, what is the date of your sobriety? _____

In planning for work, how concerned are you about loss of SSI/SSDI benefits? _____

_____

_____

This is the best estimate of my abilities and limitations.

_____
Signature

Submit Reset Form