OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
VOCATIONAL REHABILITATION AND VISUAL SERVICES APPLICATION

Name ______________________________ SSN ____________________

What is your disability? ____

____

Onset of Disability ____________________

Describe how your disability impairs your ability to work (or to live independently)?

____

____

What services do you need? ____

____

Have you ever applied for rehabilitation services? ☐ yes ☐ no
If yes when? ____________________

Do you have a Ticket to Work? ☐ yes ☐ no Ticket Number ____________________

Have you ever been convicted of a felony? ☐ yes ☐ no

Have you ever defaulted on a student loan? ☐ yes ☐ no

My completion of this document constitutes an application for Rehabilitation Services. In order to effect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. All information both medical and personal given or made available to the agency shall be held to be confidential. Use of such information will be limited to purposes directly connected with the administration of my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended by Rehabilitation Amendments of 1992 and 1998; Title 56, Oklahoma Statute 1971, sections 328 through 330 and Title 51 Oklahoma Statute 1985, Section 24A.1 through 24A.18. Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Otherwise, information will not be disclosed to any individual, agency or organizations without my written consent or that of my parent, guardian or representative as applicable.

I attest under penalty of perjury that I am (check one of the following)

☐ A Citizen or national of the U.S. ☐ A Lawful Permanent Resident ☐ An Alien authorized to work

Information provided is subject to verification through the Social Security Administration.

Client ______________________________ Date ____________

Parent/Guardian/
Representative ______________________________ Date ____________

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES

(56 O.S. § 71)

Statement Under Penalty of Perjury

(12 O.S. § 426)

I ______________________________ (D.O.B.) ______________ , hereby state as follows:
(Applicant)

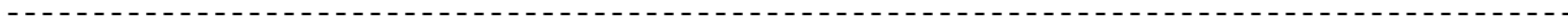
I am a United States Citizen.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

____
Date

____
County

____
[Signature of Applicant]



I ______________________________ (D.O.B.) ______________ , hereby state as follows:
(Applicant)

I am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

____
Date

____
County

____
[Signature of Applicant]

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
CLIENT INFORMATION FORM

SSN ______________________

Name ______________________________

Preferred Name ____________________ Honorific ___________ (Jr., MS, PhD., etc.)

Male ☐ Female ☐ Birth date: ________________

Previous Last Name ____________________ Previous First Name ____________________

Home Address ____
(Street, Route, P.O. Box #, etc.)

City: ______________ State: ______________________ Zip: ________ — ________

County: ______________________________

Mailing Address if different from above: ____

Primary Phone Number __________________ ☐ Voice ☐ TDD ☐ Fax

Second Phone ________________________ ☐ Cell ☐ Work ☐ Alternate

E-Mail Address: ____

Direction to Home: ____

RACE & ETHNICITY:
If Hispanic or Latino check more than one. Ex: Hispanic & American Indian

☐ White ☐ Black or African American ☐ Hispanic or Latino
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander

Is your primary language: ☐ English ☐ American Sign Language
☐ Native American language ☐ Spanish ☐ Vietnamese ☐ Other

Do you require an alternate correspondence format:
☐ Audio Tape ☐ Braille ☐ Large Print ______________________ Other

Will you require any other accommodations? ____________________

List three people whom we may contact in an attempt to locate you, should your current contact information become outdated.

1. Last Name: __________ First Name: __________
   Relationship: __________ Address/City __________
   Home phone: __________ Cell or work phone: __________
   E-Mail address: __________
2. Last Name: __________ First Name: __________
   Relationship: __________ Address/City __________
   Home phone: __________ Cell or work phone: __________
   E-Mail address: __________
3. Last Name: __________ First Name: __________
   Relationship: __________ Address/City __________
   Home phone: __________ Cell or work phone: __________
   E-Mail address: __________

Do you live in a private residence? ☐ yes ☐ no

Other: __________

What is your home county of residence? __________

Marital Status: ☐ divorced ☐ married (includes common-law)
☐ never married ☐ separated ☐ widowed

Who referred you to us? __________

Number of family living in your household: __________

LIST ALL HOUSEHOLD MEMBERS WITH INCOME INFORMATION
(Include Wages, SSI, SSDI, TANF, Worker's Comp., Unemployment, etc.)

Name	Relationship	Source of Income	Monthly Amount
	Self		

Please check if you have:

- ☐ Medicare ☐ Medicaid
- ☐ Private Insurance through own employment
- ☐ Private Insurance through other means
- ☐ Public insurance from other sources
- ☐ None

Primary Insurance Carrier ____________________

Policy Number ____________________

Medicaid Number ____________________ Medicare Number ____________________

Level of Education attained at time of this application: ____________________

Have you received services under an Individualized Education Program (IEP)? ☐ yes ☐ no

Are you currently a high school transition program participant? ☐ yes ☐ no

High School

School Name City & State

Highest Grade Completed Dates Attended

College (Most Recent)

School Name City & State

Graduated ☐ yes ☐ no

Area of Study

Hours Earned Degree Earned Dates Attended

Technical

School Name City & State

Program Completed ☐ yes ☐ no

Area of Study

Degree/Certificate Earned Dates Attended

Other Training

School Name City & State

Area of Study ______ Program Completed ☐ yes ☐ no

Degree/Certificate Earned ______ Dates Attended ______

List Your Last Three Jobs:

1. ______
(Current Job Title) (Employer name & Address) (Weekly Hours) (Weekly Salary)

(Dates Employed: MM/YY – Present) (Disability-related Problems Affecting job)

2. ______
(Job Title) (Employer name & Address) (Weekly Salary)

(Dates Employed: MM/YY – MM/YY) (Reason for leaving)

3. ______
(Job Title) (Employer name & Address) (Weekly Salary)

(Dates Employed: MM/YY – MM/YY) (Reason for leaving)

4. Other Work Experience: ______

*****

Are you currently receiving services from the following programs?

☐ American Indian Tribal VR Program ☐ Hissom

☐ Transition – Tech Now

Are you a Veteran? ☐ yes ☐ no

(If yes, list serial number and dates of service ______)

Do you have a Military Service Connected Disability? ☐ yes ☐ no

Migratory or Seasonal Farm Worker Program? ☐ yes ☐ no

Projects with Industry? ☐ yes ☐ no

Once you complete the application, please print it out. Check to see that all seven (7) pages printed.

Call for an appointment and bring the application with you, along with any pertinent medical records.

To find the nearest office, call 1-800-487-4042.