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

VR-04 (7/14)

Please print or type all entries

NAME Last *First* *Middle Initial*	GENDER ☐ Male ☐ Female
If you have been known by **another name,** enter here: *Last* *First* *Middle Initial*	
HOME ADDRESS *Street* *Apartment Number*	
City *State* *Zip +4 Code* *County*	SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐
If your **MAILING ADDRESS** is different than your home address, please complete the mailing address information below.	
MAILING ADDRESS *Street* *Apartment Number*	
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
Area code 1. ( ) *Home* ☐ *Cell* ☐ *Other* ☐ *Area code* 2. ( ) *Home* ☐ *Cell* ☐ *Other* ☐ *Email:*_____	1. 2.	Month Day Year ☐☐-☐☐-☐☐

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: (Check Box) ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ 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. • • •

You do not have to answer these questions now, but 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 answered yes, indicate agency names(s), address(es) and contact person(s):

(1)

(2)

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 NYS driver's license? ☐ Yes ☐ No

Do you have a driver's license from a state other than New York? ☐ 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

Are you a veteran? ☐ Yes ☐ No

Are you a citizen of the United States? ☐ Yes ☐ No

If no, are you legally permitted to work in this country? ☐ Yes ☐ No

Check the benefits you now receive:
☐ SSI ☐ SSDI ☐ Workers Compensation

☐ Other, specify _____

Do you regularly see a doctor or clinic about your disability? ☐ Yes ☐ No If yes, indicate date of last visit: _____
Please provide the name and address of doctor(s) and clinic(s):
(1) (2)

List the highest grade you have successfully completed: _____
and check the applicable box(es)
GED or High School Equivalency Diploma ☐ Yes ☐ No ☐ College ☐ Graduate School ☐ 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: *Name of School* *Address*

List below other people in your household

Full Name	Age	Their Relationship to You

List below the people ACCES-VR can contact if we are unable to reach you using the information on page 1.

Name	Address	Phone

List below your work history (include attachments for additional Jobs, if necessary)

Employer Name and Address	Dates Employed From - To	Weekly Earnings	Job Title and Duties, and Reason for Leaving

Persons applying foro r receiving rehabilitation services have the right to have any actions or decions of this Office reviewed. A description of the review process and form can be obtained from any ACCES-VR District Office.

All information will be kept confidential and is subject to verification.