Division of Rehabilitation Services
MARYLAND STATE DEPT. OF EDUCATION
2 South Bond Street, Suite 102
Bel Air, MD 21014
Phone: 410-836-4590; Fax: 410-836-4584

APPLICATION FOR REHABILITATION SERVICES

Referral Information

Social Security Number: _____
Name (Last, First, Middle): _____
What do you prefer to be called? _____
Please list any previous last names (e.g. maiden name, etc.): _____
Gender: ☐ **Male** ☐ **Female** **Birth date:** _____
Who referred you to DORS? _____

Home Address (house number and street address, apt., etc.): _____
City: _____ **State:** _____ **Zip Code:** _____
County: _____
Mailing Address:(if different from home address) _____
City: _____ **State:** _____ **Zip Code:** _____
Phone: _____ ☐ Home ☐ Cell Phone ☐ Fax ☐ TDD ☐ Videophone ☐ Work
Second Phone: _____ ☐ Home ☐ Cell Phone ☐ Fax ☐ TDD ☐ Videophone ☐ Work
Email Address: _____

What is your living arrangement, and who do you live with at this time? _____
_____

Emergency or Other Contacts:
Name: _____ **Relationship:** _____
Phone/TDD: _____ **Email:** _____
Name: _____ **Relationship:** _____
Phone/TDD: _____ **Email:** _____

Characteristics

Please identify your race/ethnicity (check all that apply):
☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander ☐ White
Are you Hispanic or Latino? ☐ Yes ☐ No

Do you need assistance with communicating in English? ☐ Yes ☐ No
Please explain: _____
Do you need assistance with reading English? ☐ Yes ☐ No
Please explain: _____

What is your primary language?
☐ English ☐ Chinese ☐ Korean ☐ Russian ☐ Spanish ☐ Vietnamese
☐ American Sign Language (ASL) ☐ Contact Signing/PSE ☐ Signed Exact English ☐ Foreign Sign Language
☐ Speech Reading ☐ Tactile Communication ☐ Other: _____

How would you prefer to receive written communication?
☐ Standard Print ☐ Braille ☐ Large Print ☐ Electronic Format/E-mail ☐ Audio Recording

If you would like DORS staff to send job leads, appointment reminders, schedule changes and other updates to you by text message, please indicate your cell phone number and cell phone service provider/carrier:
Cell Phone Number: _____
Provider: ☐ AT&T ☐ Alltel ☐ Boost Mobile ☐ Cricket ☐ Metro PCS ☐ Net10 ☐ Sprint PCS ☐ Straight Talk
☐ T-Mobile ☐ TracFone ☐ US Cellular ☐ Verizon ☐ Virgin Mobile ☐ Other: _____

Are you a U.S. Citizen? ☐ Yes ☐ No **If not, are you authorized to work in the U.S.?** ☐ Yes ☐ No

To obtain this Application in Braille, in large print, on disk or in other format, see your DORS counselor or call 1-888-554-0334.

Employers by law must require all new hires to fill out a federal I-9 "Employment Eligibility Verification" form based on certain forms of I.D. Which of the following forms of ID do you currently possess for I-9 verification? Please check all that apply: ☐ U.S. Passport ☐ Driver's License ☐ State/Government-issued ID Card ☐ U.S. Military ID
☐ Permanent Resident Card ("Green Card") – Alien Registration Number: _____ Expiration: _____
☐ Social Security Card ☐ Birth Certificate ☐ None
If you have no I.D., have you applied for I.D.? ☐ Yes ☐ No

Please describe any special needs or work-related concerns you may have (e.g., personal care assistance, child care, transportation, criminal background): _____

Please indicate below any programs or services with which you are involved at this time:

☐ Center for Independent Living
☐ Child Protective Services
☐ Community Rehabilitation Program
☐ Department of Correction or Juvenile Justice
☐ Department of Labor, Licensing, & Regulation (DLLR)
☐ Department of Social Services (DSS)
☐ Developmental Disabilities Administration (DDA)
☐ Disability Organization or Advocacy Group
☐ Mental Hygiene Administration (MHA)
☐ Maryland Department of Disabilities (MDOD)
☐ Educational Institution (high school or post-secondary)
☐ Employer-funded services
☐ Employment Network through Social Security Ticket-to-Work Program: _____
☐ Federal Student Aid Program
☐ Medical Health Provider
☐ Mental Health Provider
☐ One-stop Employment/Training Center
☐ Other VR State Agency (Out-of-State)
☐ Public Housing Authority
☐ Social Security Administration (e.g. Disability Determination Services or local office)
☐ Veterans Administration
  ☐ Yes, I have a Service-Connected Disability
☐ Workers Compensation
☐ Other Source: _____

Financial Information

How many dependents do you have, including yourself? _____
What is your gross monthly family income? $ _____

What is your primary source of support?
☐ Personal Income (employment earnings, interest, dividends, rent, retirement including Social Security retirement)
☐ Public Support (SSI, SSDI, Other Disability, TANF, VA, General Assistance, Worker's Compensation, etc.)
☐ Spouse, Family and Friends
☐ Other Sources (private disability insurance and private charities)

Please identify your SSDI (Social Security Disability Insurance) Status:
☐ Allowed/Receiving Benefits ☐ Denied Benefits ☐ Application Pending ☐ Benefits Discontinued/Terminated
☐ Not an Applicant ☐ Status Not Known

Please identify your SSI (Supplemental Security Insurance) Status:
☐ Allowed/Receiving Benefits ☐ Denied Benefits ☐ Application Pending ☐ Benefits Discontinued/Terminated
☐ Not an Applicant ☐ Status Not Known

Please list all benefit amounts (per month):
SSI Type: ☐ Aged ☐ Blind ☐ Disabled $ _____
SSDI: $ _____
VA (Veterans Benefits): $ _____
TANF (Dept. Social Services): $ _____
General Assistance (Dept. Social Services): $ _____
Other Disability: $ _____
Workers' Compensation: $ _____
Other: $ _____

What medical insurance do you have? (check all that apply)
☐ None ☐ Medicaid/Medical Assistance ☐ Medicare ☐ Workers' Compensation
☐ Other Public Insurance Source: _____
☐ **I am employed and have private insurance through my own job.**
☐ **I am employed, and will have private insurance through the job I am doing now after a set period of time.**
☐ **I have private insurance through other means (parent or other family member or the Affordable Care Act).**
If you have insurance, who is the policy holder? _____
Medicaid Number: _____
Medicare Number: _____
Primary Adult Care (PAC) Number: _____
Worker's Compensation Claim Number: _____

Education Information & History

If you are currently in high school:

What grade are you in? _____ **What school do you attend?** _____

What year did you begin high school? _____ **What year will you graduate or exit school?** _____

When you graduate or exit school, do you expect to receive ☐ a diploma or ☐ a certificate?

Are you receiving education services and support under a 504 Accommodation Plan? ☐ Yes ☐ No

If not, are you receiving education services under an Individualized Education Plan (IEP)? ☐ Yes ☐ No

If you are not currently in high school:

Did you receive education services under an Individualized Education Plan (IEP) during your last year of high school? ☐ Yes ☐ No

If yes, did you graduate or exit school with a diploma or a certificate? ☐ **Diploma** ☐ **Certificate** ☐ **Neither**

What is the highest level of education you completed?

☐ No formal schooling
☐ Grades 1-8
☐ Grades 9-12 (no diploma)
☐ Certificate of Completion
☐ High School Diploma or GED
☐ Post-Secondary Education (no degree or certificate)
☐ Vocational/Technical Certificate
☐ AA Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Higher than a Master's Degree
☐ Credential after Bachelor's Degree
☐ Credential after Master's Degree

If applicable, describe all post-secondary training/education that you have received: _____

_____

Employment Information

Are you currently employed? ☐ Yes ☐ No

If you are employed, how many hours do you work per week? _____

What is your salary or hourly wage? $ _____ ☐ annual ☐ monthly ☐ weekly ☐ hourly

If you are not employed, when was the last year you were employed? _____

Work History - *Please list your full work history, and start with most recent job first, or provide copy of your resume:*

Employer: _____ Start Date: _____ End Date: _____
Address: _____
Job Title: _____ Job Duties: _____
_____
Average Hours Worked Per Week: _____ Salary: _____
Reason for Leaving: _____

Employer: _____ Start Date: _____ End Date: _____
Address: _____
Job Title: _____ Job Duties: _____
_____
Average Hours Worked Per Week: _____ Salary: _____
Reason for Leaving: _____

Employer: _____ Start Date: _____ End Date: _____
Address: _____
Job Title: _____ Job Duties: _____
_____
Average Hours Worked Per Week: _____ Salary: _____
Reason for Leaving: _____

Please attach any additional work history.

Disability Information – *Please list and describe your disabilities, beginning with your primary disability:*

1. **Disability:** _____ **Date of onset:** _____
   This disability is a result of: _____
   How does this disability limit your ability to obtain employment, work, or live independently?
   _____
   _____

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2. **Disability:** _____ **Date of onset:** _____
This disability is a result of: _____
How does this disability limit your ability to obtain employment, work, or live independently?
_____
_____

3. **Disability:** _____ **Date of onset:** _____
This disability is a result of: _____
How does this disability limit your ability to obtain employment, work, or live independently?
_____
_____

Other Information

What do you hope to gain from participating in rehabilitation services (i.e., the kind of work you want to do or your independent living goals)?

_____
_____
_____

Other comments, concerns or additional information:

_____
_____
_____

REQUEST FOR SERVICES AND NOTIFICATION OF RIGHTS

I am requesting rehabilitation services and have been given a copy of the Opening Doors to Employment, Informed Choice and Client Assistance Program brochures. I understand my rights and responsibilities under this program. Information that I have provided is to the best of my knowledge true, correct and complete. I understand that giving DORS untrue and/or fraudulent information may result in services not being provided or continued. By signing this request I give permission for DORS to verify my status as a recipient of Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI).

Before signing, please discuss with your DORS counselor any information you do not understand.

Applicant Signature/Date: _____

Signature of Parent or Representative: _____
(if under age 18 or legal guardianship)

INFORMATION GATHERING

- The principal purposes served by gathering information requested on the Application, Financial Statement and individualized plan of services are 1) to determine your eligibility for rehabilitation services; 2) to determine what, if any financial participation you may be expected to provide; and 3) to plan your services.
- Refusal to provide the requested information will result in DORS finding you not eligible for services.
- You have a right to review, amend or correct the requested information under Maryland Annotated Code, State Government Article, Section 10-611-10-629.
- The requested information is not available for public inspection, unless you give written permission.
- The requested information is routinely shared with other governmental agencies when information is needed for you to obtain benefits or services; for audit, evaluation or research purposes connected with the administration of the rehabilitation program as long as confidentiality is safeguarded; and to obtain payment for services which have been provided when covered by third party resources.
- DORS requests the Social Security Number of applicants for services and uses it only for federal reporting purposes and, as applicable: (1) confirmation of Social Security benefits and presumption of eligibility, and (2) financial transactions.

Maryland State Department of Education

Division of Rehabilitation Services

Health Status: Self Report

Name: _____ **Participant ID:** _____

Date of Birth: _____

DORS needs information about your disability/disabilities to see if you are eligible for our program and what services you will need to get and keep a job or become more independent. DORS staff will keep this information confidential according to federal and state law.

What is your disability? _____

		Yes	No	Explanation
a.	Have you ever had a physical, mental or other problem which kept you from working or being independent?	☐	☐	
b.	Are you currently under the care of a doctor, psychologist or therapist? (Please list on the back or at the end of this form.)	☐	☐	
c.	Do you currently require the use of prescription medications? What are they and for what condition?	☐	☐	
d.	Do you use or need some kind of assistive device or accommodation to help you function independently (eye glasses, hearing aid, braces, wheelchair, artificial limb or similar device)? What are they?	☐	☐	
e.	Have you ever had a head injury or lost consciousness?	☐	☐	
f.	Do you have a diagnosis or medical history of substance abuse or alcohol abuse?	☐	☐	
g.	Are you HIV positive or do you have AIDS?	☐	☐	
h.	Do you need assistance with routine activities of daily living (dressing, personal hygiene, meal preparation, household chores)?	☐	☐	
i.	Do you have difficulty with such things as remembering, following instructions, doing what others expect of you?	☐	☐	
j.	Do you have difficulty reading or understanding?	☐	☐	
k.	Have you been told you have a "learning disability?"	☐	☐	
l.	Have you had special education services?	☐	☐	
m.	Do you have other health problems affecting you ability to work which are not listed here?	☐	☐	

How does your disability make it difficult for you to work, get the job you want, or be independent? _____

_____

What accommodations (devices or assistance) do you need in a school or work setting?

_____

_____

MEDICAL INFORMATION

Please complete the following about your current health care providers:

Family Doctor/HMO: _____
Address: _____
Phone: _____ **Date Last Seen:** _____
Current Treatment/Medications: _____
_____
Side Effects: _____
_____

Specialist's Name: _____ **Specialty:** _____
Address: _____
Phone: _____ **Date Last Seen:** _____
Current Treatment/Medications: _____
_____
Side Effects: _____
_____

Specialist's Name: _____ **Specialty:** _____
Address: _____
Phone: _____ **Date Last Seen:** _____
Current Treatment/Medications: _____
_____
Side Effects: _____
_____

HOSPITALIZATION/TREATMENT

Please list all hospitalizations within the last 2 years:

Facility: _____ **Dates:** _____
Address: _____
Condition treated: _____
_____

Facility: _____ **Dates:** _____
Address: _____
Condition treated: _____
_____

To the best of my knowledge, the information I have provided is complete and correct.

Applicant Signature/Date: _____

Maryland State Department of Education

Division of Rehabilitation Services
REQUEST for CONFIDENTIAL INFORMATION

Return to: _____

Office Phone: 410-836-4591
Office Fax: 410-836-4584

TO:

Name of Organization: _____
Name of Provider: _____
Address of Provider: _____
Fax Number of Provider: _____

RE:

Name of Consumer: _____
Address of Consumer: _____
Last 4 Digits of Social Security Number: _____ **Participant ID:** _____
Date of Birth: _____

Disclose or disclosure means the communication of personal information about an applicant or eligible individual or the release of records containing personal information about an applicant or eligible individual. COMAR 13A.11.06.02B(3).

My signature below authorizes the above-named source to disclose to the Division of Rehabilitation Services (DORS) the following protected health information (PHI) and/or other confidential information, which may include:

- Information regarding treatment, hospitalization and/or outpatient care for my impairments, including summaries and reports of psychological or psychiatric impairment(s) (except "psychotherapy notes" as defined in 45 CFR 164.501), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS) or tests for HIV/AIDS, or sexually transmitted diseases; and

- Information about how my impairment(s) affect my ability to complete activities of daily living and work activities:

☐ Hospital Admission/Discharge Summaries
☐ Psychological or Psychiatric Reports
☐ Transcripts/School Records
☐ Ticket to Work Status
☐ Other: _____
☐ Social History
☐ Medical Documentation
☐ Social Security Records
☐ High School Exit Document

See your DORS counselor to obtain this form in Braille, on disk or in other format.

I authorize the disclosure of this information for the following purposes:

- ☐ Determining my eligibility for services and/or determining appropriate rehabilitation services
- ☐ At my request

Dates of Services: _____

My signature indicates that I am aware of DORS policies and procedures relating to confidentiality and disclosure of records, and that I am aware that this consent can be revoked in writing at any time. My signature also means that I have read and/or had explained to me the above information and understand it. I agree that a copy of this authorization, including an electronic copy, be accepted with the same authority as the original. I understand that I may request a copy of this form.

I understand that signing this form is voluntary, but failing to sign it, or revoking it before DORS receives necessary information, could prevent a timely determination of eligibility or appropriate services.

This consent, unless revoked by me in writing, is:

- ☐ Valid for more than 45 days and continuing from date of signature while I receive rehabilitation services from DORS;
- ☐ Valid for 45 days from date of signature; or
- ☐ Expires on the following date: _____

Signature/date of Individual/Representative: _____

Signature/date of DORS Staff: _____

Information provided will become part of DORS record of services for the individual. DORS is not a health plan or health care provider; if PHI is redisclosed by DORS, the released information may no longer be protected by the privacy provision of 45 CFR part 164 mandated by the Health Insurance Portability and Accountability Act (HIPAA), but may be protected by Maryland law. DORS, however, will only redisclose such PHI and/or other confidential information in strict accordance with applicable federal and State laws and regulations. Information which DORS believes may be harmful to the individual will be released only to the individual's representative.

Maryland State Department of Education

Division of Rehabilitation Services

Financial Statement

Name: _____ **Participant ID:** _____

Date of Birth: _____

Part I. (to be completed by applicant/eligible individual)

Do you receive Public Assistance income maintenance payments, Supplemental Security Income (SSI) disability payments (because of your own disability) or Social Security Disability Insurance (SSDI) payments (because of your own disability)?

☐ **Yes** ☐ **No**

- If you answered **yes** and are requesting **vocational rehabilitation** services, read and sign Part IV.
- If you answered **no** or if you are requesting **independent living** services, proceed to Part II.

Part II. (to be completed by applicant/eligible individual)

A. Do you support yourself financially? ☐ **Yes** ☐ **No**

B. <u>Financially Responsible Persons.</u>

Indicate below the name and relationship of the persons who:

- **Claim you as a dependent for federal income tax purposes:**
  Name: _____ **Relationship:** _____
- **Are required to provide financial information on your Free Application for Federal Student Aid if you will be attending college:**
  Name: _____ **Relationship:** _____

Financially responsible person(s) named in B should complete Part III. If no one is named in B, you will complete Part III.

Part III. (to be completed by applicant/eligible individual or financially responsible person(s) named in Part II)

Reported Income:

Annual Adjusted Gross Income (from IRS 1040)		$ _____
<u>Add</u> Annual Non-Taxable Income		+ _____
	TOTAL	= 0.00
<u>Subtract</u> Medical & Dental Expenses (as reported on line 4 of IRS Schedule A)		- _____
	TOTAL	= 0.00
<u>Subtract</u> Disability-related Expenses (not included in Medical & Dental Expenses)		- _____
	TOTAL Available Income	= $ 0.00

See your DORS counselor to obtain this form in Braille, in large print, on disk or in other format.

Number of persons dependent on reported income: ____

Part IV. (to be signed by the applicant/eligible individual and, if applicable, other financially responsible persons)

The financial information I have provided is, to the best of my knowledge, true, correct and complete. DORS policy and state regulation regarding comparable services and benefits and determination of financial need and participation have been explained to me. I understand that my financial status and the amount of financial participation will be reevaluated annually. I also understand that I am required to report to the DORS counselor any substantial change in my financial status.

_____	_____
Signature of Applicant/Eligible Individual	Signature of Other Financially Responsible Person
Date: _____	Date: _____

Part V. (to be completed by DORS counselor)

Obtain the following information from Part III of this form.

$ 0.00 Available Income

_____ Number of persons dependent on reported income

Use the Financial Participation Schedule to complete the following:

$ _____ Individual/family annual financial participation

Indicate the documents **(most recent)** that have been reviewed and verify the available income of the applicant/eligible individual or other financially responsible person.

- ☐ IRS Form 1040, 1040A or 1040EZ
- ☐ IRS Schedule A of Form 1040
- ☐ Public Assistance, SSI or SSDI award letter, check, case note confirming DORS staff verification of SSI/SSDI, or other substantiation
- ☐ Pay stub
- ☐ Information substantiating disability-related expenses
- ☐ Other (specify): _____

Copies of the above documents, as indicated, shall be placed in the individual's record.

DORS Counselor Signature/Date: _____

Maryland State Department of Education
Division of Rehabilitation

Beginning the Job Search: Consent for Disclosure

Consumer Name:_____ **Date:**_____

We are now ready to begin assisting you with your job search, based on your interests, skills, capabilities, and the employment goal on your Individualized Plan for Employment. This document clarifies and confirms how DORS will assist you, based on your preferences.

Disclosure of Disability

Some individuals with disabilities agree to have a potential employer know that he or she has a disability; some individuals do not want a potential employer to know. Whether or not you prefer for an employer to know that you are a person with a disability and have received services from DORS will have an impact on how directly your DORS counselor, other DORS staff and community programs may be able to assist you in seeking employment.

If you consent to allow DORS to discuss with a potential employer that you have a disability, DORS staff may discuss the nature of the disability only in general terms, to the degree that it relates to the performance of essential functions of a particular position.

For more information on disclosure, see the Job Accommodation Network website.

DORS Job Search Assistance

Whether or not you consent to disclosure that you are a DORS consumer and have a disability will affect the way DORS can work with you to find a job, as follows:

If you consent to disclosure and agree that potential employers will most likely realize you are a person with a disability by your involvement with DORS, this means that:

- DORS staff will fully involve you in the process of identifying possible jobs.
- DORS staff may provide information identifying you and your skills and abilities to employers on your behalf, in person, in writing, including via electronic means, or via phone.
- DORS staff will share your resume with businesses that are specifically recruiting individuals with disabilities who possess your skills and abilities.
- If you are working with a community program, they will also work with you as described above, involving you in the process, working directly with you and employers and acting on your behalf during the job search.

If you do not want DORS to disclose to possible employers that you are a person with a disability and being assisted by DORS, this means that:

- DORS staff will provide you with information about jobs that seem appropriate for you but will not forward information identifying you to employers.
- You, and your family and others you choose, will be responsible for finding a job for you.
- If you are working with a community program, we will advise that program of your preferences and request that they work with you "behind the scenes."

My decision is as follows:

☑ **I consent for DORS staff, and staff of community programs, as applicable, to work directly with me and with employers, on my behalf, in finding employment consistent with my interests, capabilities and employment goal. I understand that in so doing, employers will be informed that I am a person with a disability.**

This consent, unless revoked by me/my representative in writing is (please check one):

☑ Valid for more than 45 days and continuing from the date of signature while I receive rehabilitation services from DORS; or

☐ Valid for 45 days from date of signature; or

☐ Expires on (date): _____

Consumer/Representative Signature and Date: _____

☐ **I *do not* consent for DORS staff to disclose to potential employers that I am a consumer of DORS and/or that I have a disability. I recognize that only indirect job assistance will be provided, considering this decision.**

Consumer/Representative Signature and Date: _____

Maryland State Department of Education
Division of Rehabilitation Services

Voter Registration Certification

The Division of Rehabilitation Services is an agency designated to offer the opportunity to apply to register to vote in Maryland. Please answer the following questions and sign the bottom.

Note: Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

[ ] Yes [ ] No [ ] Already registered [ ] Took form home
[ ] Not eligible to register:
[ ] Under age 18
[ ] Not a U.S. citizen
[ ] Not a Maryland resident – refer to state of residence to register
[ ] History of felony conviction – refer to Maryland Board of Elections regarding restoration of voting rights

If you do not check any box, you will be considered to have decided not to register to vote at this time.

If you would like help in filling out the registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a written complaint with:

Maryland State Board of Elections
P.O. Box 6486
Annapolis, MD 21401-0486

Or call 1-800-222-VOTE

Signature: _____

Participant ID: _____