TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES

Application for VR Services

Name:
Case ID:
Social Security:
Home Telephone:
Case # :
Date of Birth:
Gender:

Street:
Suite/Apt:
City:
State: Zip:
Email:

Referral Received Date:
Previously a VR Client?

Referral Source:

Involvement with Other Agencies and Services at Application (Select up to 3)

Other Agencies and Services 1:

Other Agencies and Services 2:

Other Agencies and Services 3:

Race/Ethnicity:

- [ ] White?
- [ ] Black or African American?
- [ ] American Indian or Alaska Native?
- [ ] Asian?
- [ ] Native Hawaiian or Pacific Islander?
- [ ] Hispanic or Latino?

Impairments

Primary Impairment

Impairment:

Cause:

Client's description of limitations due to impairment:

Secondary Impairment

Impairment:

Cause:

Client's description of limitations due to impairment:

Education Level Achieved at Application

Student with Disability in Secondary Education at Application

Current High School Student? [ ]

Marital Status:

Number of Persons Living in Household: [ ]
Number of Dependents: [ ]

Living Arrangement:

Travel Information (Choose all that apply):

- [ ] Alone?
- [ ] W/Sighted Guide?
- [ ] W/Cane?
- [ ] On Public Transportation?
- [ ] W/Assistive Devices?
- [ ] W/White Cane?
- [ ] W/Dog Guide?
- [ ] At Night?
- [ ] During Day?
- [ ] W/Wheelchair?
- [ ] Other?

Employment at Application:

Previously Employed? [ ]
Year Last Employed: [ ]
Is Client Working? [ ]
Work Status:

Federal Reported Information

Work Status:

Pay Period:		**Amount:**	
Hours per week:		**# of Jobs:**	
Days per week:		**Earned:**	

Career Exploration:

What are your personal, vocational and financial goals?

In what areas do you have work skills?

What are your work environment preferences?

What are some of your daily activities?

Medical Insurance Coverage at Application:

- ☐ Any Medical Insurance at Application?
- ☐ TennCare?
- ☐ Medicare?
- ☐ Public Insurance from Other Sources?
- ☐ Not Yet Eligible for Private Insurance through Current Employer?
- ☐ Private Medical Insurance through Own Employment?
- ☐ Private Medical Insurance through Other Means?
- ☐ Veteran's Benefits?

Other Income Source at Application:

Please Enter Monthly Amount

AMOUNT	
	SSI for Aged
	SSI for Blind
	SSI for Disabled
	Families First
	General Assistance (State or Local Government) NOT FEDERAL
	Social Security Disability Insurance (SSDI)
	Veterans' Disability Benefits
	Worker's Compensation
	Government Retirement
	Survivor Benefits
	Unemployment Compensation
	Other Private Sources (insurance payments, private charity, etc.)
	Social Security Retirement
	Annuity or Other Non-Disability Insurance
	Other Public Assistance
	Total

☐ Foodstamps?

Primary Source of Support at Application:

Contacts:

Last Name: First Name:
Title:

Last Name: First Name:
Title:

Medical Doctor:

Clinic/Hospital:
Name:
Address:

Phone:
Fax:
Specialty:

Special Categories (Y=Yes N=No):

Honorably Discharged Veteran? ☐
Projects with Industry? ☐
Has the Client ever received services under an Individualized Education Program? ☐
Service Related Disability? ☐
Eligible to Work in the USA? ☐
Social Security Card ? ☐
Birth Certificate ? ☐
Valid Driver's License ? ☐ Picture ID ? ☐

Special License or Restrictions ? ☐
Can you pass a drug screen ? ☐
Can you pass a background check ? ☐
Have you ever been arrested ? ☐
Previous Criminal History? ☐

Communication:
Primary Language:
Other Languages:
Manual Communication Mode:
Preferred Written Communication Medium:

Have you received a Ticket to Work from Social Security? ☐

Application and Eligibility Process:

Your Vocational Rehabilitation (VR) Counselor will assess your eligibility for services within 60 days. The assessment is based on information documenting your disability provided by you or obtained from evaluations conducted by professionals with knowledge of your disability. To be eligible for VR services, you must:

- Have a physical, mental or sensory disability that interferes with your ability to work;
- Be able to benefit from services in terms of employment;and
- Need VR services to prepare for, find, or keep a job.

If you receive Social Security Disability Insurance benefits or Supplemental Security Income benefits based on your disability or blindness, you are presumed to meet all eligibility requirements. If you are able to go to work, you will be provided information to help you understand how your benefits may be affected.

If your VR Counselor determines that your disability may be too severe for you to work, a determination of eligibility cannot be completed until you participate in Trial Work Experiences to determine if you can benefit from VR services and achieve a successful employment outcome.

If your VR Counselor cannot determine your eligibility within 60 days due to problems beyond the control of the Counselor, you will be asked to agree to an extension of time to determine your eligibility.

If the Division does not have enough money to provide services for all eligible persons,Federal law requires that priority for services be given to persons who have the most significant disabilities. If you are determined eligible for services, your VR Counselor will assess your limitations created by your disability and your need for services to obtain employment to determine your priority for services. If it is determined that services cannot be provided for you to at this time, you will be given information about other services that can help you find employment.

All information provided by you or obtained from other sources about you and your disability is confidential. This information may be released to other entities that provide services to help you find employment.

Rights of Appeal:

If you do not agree with a decision made by your VR Counselor and want to request a review of the decision, you must let your Counselor or his or her Supervisor (VIRGINIA TALLEY, Phone: (931)645-0610) know in writing or orally no later than 30 calendar days from the date of notification of the decision. If you have questions or need assistance asking for a review, please contact your VR Counselor or his or her Supervisor.

The review may include an administrative review, mediation or fair hearing. You may request any one of these methods to conduct the review. If you do not request one, an informal administrative review will be conducted within 15 days of your request. Even if the review is conducted by an informal administrative review or mediation, you may request a fair hearing at any time during or within 30 days of completion of the review or mediation. If you request a fair hearing, it will be scheduled within 60 days of your request.

A Client Assistance Program (CAP) is available to help you:

- Understand the services and benefits available from vocational rehabilitation services;
- Request and pursue a review of a decision made by vocational rehabilitation staff that affects the provision of vocational rehabilitation services; and
- Understand your rights and responsibilities under the law.

The CAP is provided by Disability Rights Tennessee. You can contact the CAP by mail at 2 International Plaza, Suite 825, Nashville, TN 37217; or call them (1-800) 342-1660 or TTY (1-888) 852-2852; or email them at **GetHelp@disabilityrightstn.org**

Nondiscrimination - In accordance with Federal law and U.S. Department of Health and Human Services policy, this Agency is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. If you feel as though you have been discriminated against or treated unfairly, you have the right to file a written complaint with the Tennessee Department of Human Services, Office of General Counsel, 400 Deaderick Street, 15th Floor, Nashville, TN 37243; or with the U.S. Department of Education, 61 Forsythe Street S.W., Atlanta, GA 30303. You may also file a written complaint of discrimination with HHS, Director Office for Civil Rights, Room 506-F, 200 Independence Avenue S.W., Washington, D.C. 20201 or call (202)619-3257(TDD). HHS is an equal opportumity provider and employer.

I hereby make application for VR services. I certify that the information provided in this application is true and correct to the best of my knowledge.

Client

Date

MASTERS VOC. REHAB. COUNSELOR

Date

TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES

Financial Participation Assessment

Name ______ (Last) ______ (First) Client# ______

☐ **PUBLIC ASSISTANCE BASED ON CLIENT'S DISABILITY AND/OR FINANCIAL CIRCUMSTANCES**

I am a recipient of SSI, SSDI, Families First/TANF or Food Stamps. I understand that I automatically meet Economic Need. This information must be verified.

ADJUSTED GROSS INCOME Based on calendar year: ______

Can be obtained from:
1040 EZ, Line 4
1040A, Line 21
1040, Line 37

1A. Client
1B. Spouse
1C. Other Financial Contributors
1D. Total Household Members
2A. Total Adjusted Gross Income

2B. If the client's total income is now less than the total income reported on the prior year's federal income tax return; or a federal income tax return was not filed; or the client has no income, list all documented sources of income, explain the client's current financial circumstances, and request an exception to policy.

Income Sources

Explanation:

DEDUCTIONS

3A. Non-reimbursed medical or dental expenses
3B. Court ordered obligations other than alimony
3C. Post-secondary educational loans currently being repaid by the client
4. Total Deductions
5. SUBTRACT LINE 4 FROM LINE 2A
6. Financial Exemption Level (based on Total Household Members)
7. Total Line 5 LESS Financial Exemption Level

☐ Requires Financial Participation? If Line 7 is greater than zero, this is the client participation level that must be applied towards the total cost of any services based upon Financial Need.

☐ I decline to provide documentation of my financial circumstances. I understand that I will only be provided services that do not require a determination of my participation in cost. I also understand that at any time I may provide documentation of my financial circumstances so that a determination can be made.

☐ I certify that the above is a true statement of my financial circumstances.

☐ I agree to notify my counselor if there is any material change in my financial circumstances.

☐ I understand that my financial circumstances must be reviewed annually by the date shown below. DRS cannot provide services after the reevaluation date until I have completed this requirement.

Client ____________________ Date __________

Masters Rehab Counselor ____________________ Date __________

Request for exception to policy:
Facts and circumstances justifying request:

Regional Supervisor

Date

Comments:

TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES

VR Case and Closure Information

Client Name:

Case ID:

Date of Birth:

Level of Education at Closure:

Student with Disability in Secondary Education at Closure:

Impairments

Primary Impairment

Impairment:

Cause:

Secondary Impairment

Impairment:

Cause:

☐ Significantly Disabled?

Significance of Disability:

☐ Projects with Industry (IAM CARES, etc.)?

The following grid shows the service types that have been provided to the Client for this Case. To add additional services provided to the Client, select the service type in the grid, and then fill in the Service Provided By. If additional Providers need to be added, fill in up to 3 providers.

Drag a column header here to group by that column.

911 Federal Services Provided to client - 2014

Ready.

Loaded 28 of 28

Service Type:

Service Provided By:

Comparable Services and Benefit Providers (Select up to 3):

Provider 1:

Provider 2:

Provider 3:

Other Income at Closure

Please Enter Monthly Amount

AMOUNT

AMOUNT	
	SSI for Aged
	SSI for Blind
	SSI for Disabled
	Families First

- [ ] General Assistance (State or Local Government) NOT FEDERAL
- [ ] Social Security Disability Insurance (SSDI)
- [ ] Veterans' Disability Benefits
- [ ] Worker's Compensation
- [ ] Government Retirement
- [ ] Survivor Benefits
- [ ] Unemployment Compensation
- [ ] Other Private Sources (insurance payments, private charity, etc.)
- [ ] Social Security Retirement
- [ ] Annuity or Other Non-Disability Insurance
- [ ] Other Public Assistance
- [ ] Total

Primary Source of Support at Closure:

Supported Employment Status at Closure:

Supported Employment Goal:

Medical Insurance Coverage at Closure:

- [ ] Any Medical Insurance at Closure?
- [ ] TennCare?
- [ ] Medicare?
- [ ] Public Insurance from Other Sources?
- [ ] Private Insurance Through Own Employment?
- [ ] Private Insurance Through Other means?
- [ ] Not Yet Eligible for Private Insurance through Current Employer ?
- [ ] Veteran's Benefits?

SVR Status:

SVR Status Date: Ineligible for SVR? [ ]

Reason for closure:
Date Closed:

VOCATIONAL REHABILITATION COUNSELOR

Date

Federal Report Information

Zip: * County: *

**Information as of application date.*

Tennessee Department of Human Services Vocational Rehabilitation Program

VR Services Progress Report

(This report, with appropriate attachments, must accompany any claim for payment)

1. Name of client: ________________________________ VR Counselor: ______________________________
2. Period of service: from ______________________ to ______________________
3. Service: ____
4. Service provider: ____
5. Location of service: ____
6. Service objective: ____
7. Attendance, if appropriate:

   Number days present______ absent______. If absent, were absences excusable? Yes_____ No_____

   Explain:____
8. Difficulties, if appropriate (check with "X" the word or words best describing items):

   Learning subject matter _____ Disability ______ Following instructions ______ Appliance ______

   Handling tools or machines _____ General health ______ Speed _____ Accuracy ______

   Other (describe) ____
9. If separate subjects or operations are involved, list and rate performance as Excellent, Good, Fair, or Poor

Subject Or Operation	Rating	Subject Or Operation	Rating

10. Is service provider transportation approved: Yes_____ No_____. If yes, attach daily log of destinations and mileage.
11. How much more time will be required (approximately) to complete the service? ____________________________
12. Recommendations/Remarks: ____

____

____

____

____

____

____ ______________________________

Service provider signature Date

DHS staff should check the "Forms" section of the intranet to ensure the use of current versions. Forms may not be altered without prior approval.
Distribution: VR Counselor (original) Service provider file (copy) *RDA: Pending*

Education History

Client:

Current/Last School/Educational Program:

Current/highest grade of school completed:

Currently/previously in a special education program? ☑

Special Education Services Received:

Home Schooled? ☐

GED attained? ☐

HS Diploma or GED Attained on:

Elementary and Secondary Education

(Only Most Recent Required)

Dates attended: through

School's Name:

GPA:

Regular Diploma? ☐

Special Education Diploma? ☐

If you did not graduate, why?

Services Provided By School:

Contacts At This School:

Last Name: First Name:

Title:

Contact Type:

College and Vocational Education

Dates attended: through

School's Name:

Street:

Suite: Zip:

City: State:

Phone:

Fax:

Website:

Major/Field of Study:

Certification/Degree:

Date Obtained:

GPA:

Are you in default on any student loans?

Vocational Training:

Other Training (e.g. military, correspondence courses, on-the-job, etc.):

Other Certifications:

Learning Preference

- [ ] Audio/Visual Materials (Learn by watching)
- [ ] Written Materials

- [ ] Demonstration/Practice (Learn by doing)
- [ ] Other
- [ ] Are you proficient in Reading?
- [ ] Are you proficient in Math?

Other Skills By Self Report

- [ ] Computer Skills?
- [ ] Typing?
- [ ] Foreign Languages?
- [ ] Adaptive Tech?

Other Skills: ____________________

TENNESSEE DEPARTMENT OF HUMAN SERVICES
VOCATIONAL REHABILITATION SERVICES

PHYSICAL CAPACITY ASSESSMENT

Client/Patient ______________________________

Physician ______________________________

Based upon your examination or your knowledge of the patient, please check all items in which there is a restriction to the extent described. Please mark **"N/A"** for any items that you are not able to answer or that are not within your area of expertise. If you prefer not to complete the form, you may instead address these areas in a narrative format. The above-named individual wants to work, and the results of this examination/information will be used to help Vocational Rehabilitation determine appropriate vocational goals and limitations. **Please assist us, and the patient, by completing this assessment and returning it as soon as possible to:**

DRS Counselor_____ Phone: _____Fax: _____

Address_____

_____

Please attach any social history, diagnostic notes, discharge summaries, office notes, x-ray reports, lab test results, etc. that are relevant to the disability and the limitations of the patient. A signed authorization to release information that meets the requirements of HIPAA is attached. Thank you in advance for your assistance.

Diagnosis______________________________

Prognosis______________________________

1. **In an 8-hour work day, can this patient (please circle):**

Sit	more than 4 hours	Sit	4 or less hours
Stand	more than 4 hours	Stand	4 or less hours
Walk	more than 4 hours	Walk	4 or less hours

2. **Patient can sustain work activity, including normal breaks for (please circle):**

more than 4 hours   4 or less hours

3. **Does the patient have any weight bearing (lifting/carrying) restrictions?** Yes ____ No ____
Please explain a "yes" response

____

____

4. **Check if the patient has restrictions involving the following activities and if so, explain briefly.**

_____ Bending, crawling or squatting ______________________________

_____ Reaching above shoulder level______________________________

_____ Unprotected heights ______________________________

_____ Being around moving machinery ______________________________

_____ Being around fixed machinery ______________________________

_____ Chemicals ____________________

_____ Exposure to dust, fumes, & gases ____________________

_____ Cold climate (40° F or less) ____________________

_____ Hot climate (90°F or more) ____________________

_____ Activity in wet/humid setting ____________________

5. **Does the patient have any significant respiratory ailments that would prevent him/her from working in certain situations?** Yes _____ No _____ *Please explain a "yes" response*

____

____

6. **Is patient unable to use public transportation because of a physical disability (including visual)?** Yes _____ No _____ *Please explain a "yes" response*

____

____

7. **Is the patient unable to operate a motor vehicle because of a physical disability (including visual)?** Yes _____ No_____ *Please explain a "yes" response*

____

____

8. **Does the patient have limited or no independent mobility because of a physical disability (including visual)?** Yes _____ No _____ *Please explain a "yes" response*

____

____

9. **Is the patient unable to carry out most activities of daily living because of a physical disability (e.g., bathing, dressing, toileting, cooking, etc.)?** Yes _____ No_____ *Please explain a "yes" response*

____

____

10. **Does the patient have a medical condition that will prevent regular, ongoing attendance on the job?** Yes_____No_____ *Please explain a "yes" response*

____

____

Additional Comments: ____________________

____

____

____________________ ____________________

Physician's Name (Print) **Physician's Signature** **Date**

Physician's Address: ____________________

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HS-2830 (9/2015)

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