

**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 type of employment are you interested in, and how can we help you achieve your goal?

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)

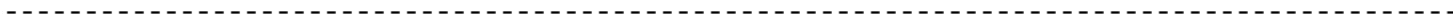
I am a United States Citizen.

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*

<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> 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 \_\_\_\_\_

Program Completed  yes  no

Area of Study \_\_\_\_\_

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: \_\_\_\_\_

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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.

Please mail or deliver the application to the Oklahoma Department of Rehabilitation Services. To find the nearest office, call 1-800-487-4042.