**MAINE DEPARTMENT OF LABOR**

**DIVISION FOR THE BLIND AND VISUALLY IMPAIRED**

**APPLICATION FOR VOCATIONAL REHABILITATION (VR)**

**APPLICATION FOR INDEPENDENT LIVING SKILLS (IL)**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | SSN #: |       |
| Previous Name (if any): |       | Birth Date: |  |
| Gender: | Does not wish to self-identify: [ ]  | Female:**[ ]**  | Male: **[ ]**  | Non-Binary: [ ]  |
| Residence (street): |  |
| City: |       | State: |    | Zip: |       |
| County: |       | E-Mail: |       |
| Mailing Address (if different): |  |
| Primary phone number: |       | Secondary phone number: |       |
| Primary number a cell phone: Yes [ ]  No [ ]  | Secondary number a cell phone: Yes [ ]  No [ ]  |
| Living Arrangement: [ ]  Private Residence Other:      |
|  |
| **Race/Ethnicity:** | American Indian /Alaska Native[ ]  | Asian[ ]  | Black or African-American[ ]  |
| Does not wish to self-identify [ ]  | Hispanic or Latino[ ]  | Native Hawaiian or other Pacific Islander [ ]  | White [ ]  |
| **Primary/Preferred Language:** |       |
| **Preferred Correspondence:** | [ ]  Audio [ ]  Braille [ ]  E-mail [ ]  Large Print (18) [ ]  Print |
| **Do you have a Legal Guardian?** [ ]  Yes [ ]  No | Name of Legal Guardian: |       |
| Phone: |       | E-mail: |       |
| Mailing Address: |       |
| **Primary Emergency Contact:** |
| Name: |       | Relationship to applicant: |       |
| Phone: |       | E-mail: |       |
| Mailing Address: |       |
| **Secondary Emergency Contact:** |
| Name: |       | Relationship to applicant: |       |
| Phone: |       | E-mail: |       |
| Mailing Address: |       |
| **Are You Registered to Vote**: [ ]  Yes [ ]  No | **If No, would you like a voter registration form?** [ ]  Yes [ ]  No |
| **Marital Status:** [ ]  Divorced [ ]  Married [ ]  Never Married [ ]  Separated [ ]  Widowed |
| **Are You a United States Citizen?** [ ]  Yes [ ] No | **If No, do you have legal status to work in the U.S.?** [ ]  Yes [ ]  No |
|  |
| **Who Referred You?** |
| Name: |       | Relationship to applicant: |       |
| Agency: |       | Phone: |       |
| Email: |       |
| **Primary Source of Support** | [ ]  Family/Friends [ ] Personal Income/Wages [ ]  Public Support (SSI, SSDI, TANF, etc.)[ ]  Other [ ]  Personal Income: Interest, Dividend and rent |
| **Disability Benefits:** |
| **Type of Benefit** | **Amount Received** | **Application** **Status** |  | **Other Income** |
|  |  | **Pending** | **Denied** |  | **Source** | **Amount** |
| **SSI-Aged** | **$** | **[ ]**  | **[ ]**  |  | **General Assistance** | **$** |
| **SSI-Disabled** | **$** | **[ ]**  | **[ ]**  |  | **Worker’s Compensation** | **$** |
| **SSDI-Disabled** | **$** | **[ ]**  | **[ ]**  |  | **Unemployment** | **$** |
| **SSDI-Other** | **$** | **[ ]**  | **[ ]**  |  | **Other Disability** | **$** |
| **VA** | **$** | **[ ]**  | **[ ]**  |  | **Other (Family income, wages, etc.)** | **$** |
| **TANF** | **$** | **[ ]**  | **[ ]**  |  | **If you receive TANF will your benefits exhaust within two years?** **[ ]  Yes** **[ ]  No** |
| **Medical Insurance:** **[ ]** Maine Care (Medicaid) [ ]  Medicare  [ ]  Private through other means [ ]  Private through own work pending [ ]  Private through own work [ ]  Public insurance from other sources [ ]  None [ ]  Not available [ ]  State/Federal Affordable Care Act Exchange |
|  |
| **Primary Doctor** |  | **Date Last Seen** |  |
| **Address of Primary Doctor:** |  |
|  |
| **Other Sources of Medical Information** |
| **Doctor/Hospital/Clinic** |  | **Date Last Seen** |  |
| **Address:** |  |
|  |
| **Doctor/Hospital/Clinic** |  | **Date Last Seen** |  |
| **Address:** |  |
|  |
| **Doctor/Hospital/Clinic** |  | **Date Last Seen** |  |
| **Address:** |  |
|  |
| **Doctor/Hospital/Clinic** |  | **Date Last Seen** |  |
| **Address:** |  |
|  |
| **OTHER AGENCIES AND SERVICES INVOLVED AT APPLICATION** |
| **AGENCY/SERVICE** |  |
| **Address:** |  |
|  |
| **AGENCY/SERVICE** |  |
| **Address:** |  |
|  |
| **AGENCY/SERVICE** |  |
| **Address:** |  |
|  |
| **AGENCY/SERVICE** |  |
| **Address:** |  |
|  |
| **Are you working:** **[ ]  Yes** **[ ]  No**  | **If NO, date last employed?**  |  |
| **Are you requesting services to maintain your current employment?** **[ ]  Yes** **[ ]  No** |
| **Work History:** (Please list starting with the most recent or present job and attach a resume if you have one)  |
| **Employer:**  |       | **Job Title:**  |       |
| **Hours per week:** |       | **Rate of pay:** |       | **Start Date:** |       | **End Date:** |       |
| **Leave Reason:** |  |
|  |
| **Employer:** |       | **Job Title:** |       |
| **Hours per week:** |       | **Rate of pay:** |       | **Start Date:** |       | **End Date:** |       |
| **Leave Reason:** |  |
|  |
| **Employer:** |       | **Job Title:** |       |
| **Hours per week:** |       | **Rate of pay:** |       | **Start Date:** |       | **End Date:** |       |
| **Leave Reason:** |  |
|  |
| **Employer:** |       | **Job Title:** |       |
| **Hours per week:** |       | **Rate of pay:** |       | **Start Date:** |       | **End Date:** |       |
| **Leave Reason:** |  |
|  |
| **Employer:** |       | **Job Title:** |       |
| **Hours per week:** |       | **Rate of pay:** |       | **Start Date:** |       | **End Date:** |       |
| **Leave Reason:** |  |
| **Are you a Veteran?** **[ ]  Yes** **[ ]  No** |
| **Have you ever been convicted of any violation of law by any court of law? Include any guilty pleas entered, military courts martial, and traffic violation convictions for Operating Under the Influence (OUI), or traffic violations that resulted in your license being suspended.** [ ] Yes [ ]  No  **Were you convicted of any crimes prior to the age of 18?** [ ] Yes [ ]  No  **Do you have a criminal record outside the State of Maine?** [ ] Yes [ ]  No  |
| **If you answered yes to any of the above three questions, please describe:** |
| *A conviction will not disqualify you from Vocational Rehabilitation Services but will be considered in relation to your vocational goal.*   |
| **Education:**  **Do you have your diploma or GED?** **[ ]** Yes**[ ]** No | **Year of graduation?**     | **If not, highest grade completed and year completed:**      | **Are you currently a student?** **[ ]** Yes**[ ]** No |
|  |  |  | **Last School you attended?**  |
| **Have you ever received services under an Individual Education Plan?** **[ ]** Yes**[ ]** No |
| **Have you ever received services under a 504 plan?** **[ ]** Yes**[ ]** No |
| **Do you have any college education, if so where?**       | **Total number of credits:** |
| **Area of study:** | **Did you graduate from college:** **[ ]  Yes** **[ ]  No** |
| **Last year in attendance:** | **Any Specialized vocational training? If so, what?** |
| **Have you applied for Vocational Rehabilitation before?** **[ ] Yes** **[ ] No** | **When/Where:**  |
| **Primary disability:** | **Cause of disability:** |
| **Secondary disability:** | **Cause of disability:** |
| **I hereby apply for Vocational Rehabilitation services as I believe I have a disability that interferes with my ability to work. I certify that I have access to a copy of the *Maine DOL Bureau of Rehabilitation Services Rights and Responsibilities* document and I understand that my vocational rehabilitation counselor is available to answer any questions I have regarding the document. I certify that to the best of my knowledge the above information is true. Failure to disclose requested information could be considered evidence of refusal to cooperate and result in closure of your case.**  |
| **Applicant Signature** |  | **Date** |  |
| **Parent/Guardian Signature** |  | **Date** |       |