Opportunities for Ohioans with Disabilities

Participant Information/Application for Vocational Rehabilitation Services

PLEASE PRINT

***Name** (First, Middle, Last)	**Suffix (e.g., Jr.)**	***Preferred Name**
***Social Security Number**	***Birth Date** (mm/dd/yyyy)	***County of Residence**

***Home Address** (Number, Street/Rural Route, City, State, Zip)	**Mailing Address** (If different from home address)

***Primary Phone No.** (10-digit) ☐ Voice ☐ Text ☐ Video ☐ TTY	***Secondary Phone No.** (10-digit) ☐ Voice ☐ Text ☐ Video ☐ TTY	**Email Address**

Preferred Method/Mode of Communication? ☐ Braille ☐ Email ☐ In-Person	☐ Phone ☐ Text ☐ Virtual ☐ Not Listed, Please Specify:	**Preferred Language?** ☐ American Sign Language ☐ English ☐ Somali ☐ Spanish ☐ Not Listed, Please Specify:	**Are Interpreter Services Needed?** ☐ No ☐ Yes, Indicate language:

Gender, Race, Ethnicity. *This information is required to be collected for federal reporting purposes. Please select the response that best reflects how you identify yourself.* ***Pronoun preference.*** *This optional information is collected to assist staff in using pronouns that should be used to refer to you.*

***Gender?** ☐ Female ☐ Male ☐ Nonbinary	☐ Prefer not to specify ☐ Not Listed, Please Specify:	**Pronoun Preference?** ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs	☐ No preference ☐ Prefer not to specify ☐ Not Listed, Please Specify:

***Race (Select *all* that apply):** ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander	☐ White ☐ Prefer not to specify ☐ Not Listed, Please Specify:	***Ethnicity (Select one):** ☐ Hispanic/Latinx ☐ Not Hispanic/Latinx ☐ Prefer not to specify ☐ Not Listed, Please Specify:

***What is your disability?**

Are you a U.S. Citizen? ☐ Yes ☐ No **If "No," please list your immigration status:**

***Are you currently working?** ☐ Yes ☐ No ***What is your hourly wage?** ***How many hours per week?**

***Are you currently enrolled in high school?** ☐ Yes ☐ No **School Name:**

***Are you currently enrolled in college?** ☐ Yes ☐ No **School Name:**

***Are you a Veteran?** ☐ Yes ☐ No

***Would you like to register to vote?** ☐ Yes ☐ No

****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***

Contact person(s): If you complete this section, you are permitting OOD to disclose to the individual that you have applied for services.

Name & Relationship	**Address** (Number, Street/Rural Route, City, State, Zip)	**Phone No.** (10-digit)

***Are you referring yourself?** ☐ Yes ☐ No ***If No, who is referral source?**

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This application will be considered complete when it is initialed and dated by VR Staff or VR Contractor at the time of your appointment.
The State of Ohio is committed to good privacy practices. As such, we are disclosing that in order to fully process your application, verify your eligibility and provide vocational rehabilitation services, Opportunities for Ohioans with Disabilities (OOD) may need to access personal information about you, such as your Social Security Number, which is maintained by OOD. By signing this application, you are requesting that OOD access any personal information necessary to process your application, determine eligibility and provide services. Please note that OOD will continue to protect any non-public, confidential personal information maintained about you from release to the public or unauthorized third parties.

OOD does not discriminate against any applicant for services on the basis of race, color, religion, national origin/ancestry, disability, age (40 years or older), sexual orientation, gender or sex, veteran or military status, and/or genetic information or in any manner prohibited by law.

I understand that in applying for services, I give my permission for OOD to obtain or release confidential personal information about me as follows:

- to purchase services for me;
- in collaboration with OOD Contractors, Partners and Employers on my behalf;
- to report my progress to the agency who referred me to OOD;
- when required by law and to facilitate the administration of the Rehabilitation Act;
- to verify my current and/or future educational status and/or credentials;
- to do research to improve the lives of people with disabilities;
- to the Social Security Administration (SSA) and/or Division of Disability Determination (DDD) when I am applying for or am a recipient of SSDI or SSI benefits; and
- in cooperation with other state agencies (Ohio Department of Job and Family Services, Ohio Department of Education, Ohio Department of Developmental Disabilities, etc.), which may include information from Temporary Assistance for Needy Families (TANF) Supplemental Nutrition Assistance Program (SNAP), if applicable. (Authorization to obtain or disclose SNAP/TANF data will expire five (5) years after the date your case with OOD is closed)

Information disclosed from the above list could potentially be re-disclosed by the recipient, in this situation, the information might no longer be considered protected by state or federal law.

Signature of Individual (If under 18, parent or legal guardian must also sign below)	**Date**
Signature of Parent or Legal Guardian	**Date**

OOD Use Only: I have explained OOD services and procedures, the individual's rights and duties, confidentiality, the Client Assistance Program (CAP), and the right to register to vote. I have provided the individual the VR Program Overview and information about exercising informed choice. I have also provided a copy of this application in the preferred mode of communication of this individual. I certify that this application is accurate.
Initials **Date**

How was this form received? ☐ Electronically ☐ Walk-In ☐ Mail ☐ Other:

Original – Counselor Copy – Applicant

*Required Information