Welcome to DVR!

DVR helps people with disabilities prepare for, obtain, keep, regain or advance in suitable jobs. If you’re completing this Applicant Information Packet, then you have or will be scheduling an appointment with a DVR Counselor who will help you navigate through our process.

Please complete as much of this form as you can and bring this information with you to your first appointment. You do not need to complete this form to apply for DVR services. However, your cooperation with providing as much information as possible will assist with the progress of your DVR case. If you need help completing this form, your DVR Counselor will assist you. All information is kept confidential.

This form and additional information can be found online at:

www.colorado.gov/dvr

To be eligible for services you must:

- Have a documented disability that results in difficulty working
- Need DVR services to achieve your employment goal
- Intend to go to work in competitive integrated employment

What do you need to apply?

- Valid photo ID and/or proof of legal presence (if 18 and over)

Items that might be helpful for you to bring to your first DVR appointment:

- Medical records (medical, psychological, vision, and/or hearing, etc.)
- Individualized Education Plan (IEP), 504 Plan
- Any Social Security letters, and/or Ticket to Work (if receiving)
- High School, college transcripts or certifications
- Any vocational testing like interests tests, Myers-Briggs, etc.
- Resume or list of jobs held

If you do not have any of the above, DVR will work with you to gather any new information needed.

Date and Time of appointment: ________________________________
Office address: _______________________________________________
Phone: _______________________________________________________
DVR counselor: _______________________________________________
**PERSONAL INFORMATION**

<table>
<thead>
<tr>
<th>SSN</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Preferred Name</th>
</tr>
</thead>
</table>

Gender  
- Male [ ]
- Female [ ]
- Prefer Not to Disclose [ ]

Birth Date _____________

Previous Last Name ________________  
Previous First Name ________________

Home Address ____________________________  
City ____________________________

State ____________________________  
Zip ______  
County ____________________________

Mailing Address ____________________________

City ____________________________  
State ______  
Zip ____________________________

Primary Phone ____________________________  
Voice [ ]  
TDD [ ]  
Cell [ ]  
Other [ ]

Second Phone ____________________________  
Voice [ ]  
TDD [ ]  
Cell [ ]  
Other [ ]

Email Address ____________________________

**Please identify the race(s) and ethnicity with which you most identify:**

- American Indian or Alaskan Native [ ]
- Asian [ ]
- Black or African American [ ]
- Hispanic or Latino [ ]
- Middle Eastern or Arab [ ]
- Native Hawaiian or Pacific Islander [ ]
- White [ ]
- Other [ ]  
- Prefer Not to Disclose [ ]

**What is your English speaking ability?**

- Functional [ ]  
- Limited [ ]  
- None [ ]  
- Unknown [ ]

**What is your English reading ability?**

- Functional [ ]  
- Limited [ ]  
- None [ ]  
- Unknown [ ]

**What is your primary language?**

- American Sign Language [ ]
- English [ ]  
- Spanish [ ]
- Other Language: Specify ____________________________

**What is your preferred correspondence format?**

- Audio Tape [ ]  
- Braille [ ]  
- Colorado Relay [ ]  
- Email [ ]  
- Large Print [ ]

- Phone [ ]  
- Text Message [ ]  
- TTY [ ]  
- Video Phone [ ]

- Written Communication [ ]

**What is your preferred alternate correspondence format?**

- Audio Tape [ ]  
- Braille [ ]  
- Colorado Relay [ ]  
- Email [ ]  
- Large Print [ ]

- Phone [ ]  
- Text Message [ ]  
- TTY [ ]  
- Video Phone [ ]

- Written Communication [ ]
Please provide an emergency contact or name of someone who will know how to reach you in the event you lose contact with DVR:

Last Name ___________________________ First Name ___________________________ MI _____

**Contact Type**

- [ ] Counselor
- [ ] Doctor
- [ ] Emergency Contact
- [ ] Family Member
- [ ] Friend
- [ ] Guardian*
- [ ] Lawyer
- [ ] Parole Officer
- [ ] Other

**Address:** ___________________________

City __________________________________ State ________ Zip ________

Primary Phone ______________________ Voice [ ] TDD [ ] Fax [ ]

Secondary Phone ____________________ Voice [ ] TDD [ ] Fax [ ]

Email Address ________________________

*If you have a legal guardian, DVR will request a copy of the guardianship paperwork.

**Please indicate your current living situation:**

- [ ] Community Residential/Group Home
- [ ] Correctional Facility
- [ ] Halfway House
- [ ] Homeless/Shelter
- [ ] Mental Health Facility
- [ ] Nursing Home
- [ ] Other
- [ ] Private Residence
- [ ] Rehabilitation Facility
- [ ] Substance Abuse Treatment Center

**Please indicate your voter registration status:**

- [ ] I am currently registered to vote and no changes are needed
- [ ] I am currently registered to vote but need to update my address
- [ ] I am not currently registered to vote and don’t want to register
- [ ] I am not currently registered to vote, and do want to apply
- [ ] I am not eligible to register

**What is your current marital status?**

- [ ] Divorced
- [ ] Married
- [ ] Never Married
- [ ] Separated
- [ ] Widowed

**Please tell us about who suggested you work with DVR:**

Organization Name ________________________________________________

Salutation:  Dr. [ ] Miss [ ] Mr. [ ] Mrs. [ ] Ms. [ ]

Last Name ___________________________ First Name ___________________________

Address ____________________________ City ___________________ State ______ Zip ______

---

AWARE
Applicant Packet - Printable
Page 3 of 9
Primary Phone ______________________  Voice ☐  TDD ☐  Fax ☐
Email Address _________________________________

**INCOME AND HOUSEHOLD INFORMATION**

Number of dependents ____________
What is your primary source of financial support? ________________________________
Do you receive Public Support (TANF, AND, Food Stamps, etc.)?  Yes ☐  No ☐

**Social Security Disability Insurance (SSDI) Status:**

☐ Applicant – allowed benefits  ☐ Applicant – denied benefits
☐ Applicant – status pending  ☐ Benefits discontinued or terminated
☐ Not an applicant  ☐ Not known if an applicant

**Supplemental Security Income (SSI) Status:**

☐ Applicant – allowed benefits  ☐ Applicant – denied benefits
☐ Applicant – status pending  ☐ Benefits discontinued or terminated
☐ Not an applicant  ☐ Not known if an applicant

**If you receive any of the following benefits, please estimate the amount of your individual monthly benefit:**

SSI Aged $________  SSI Blind $________
SSI Disabled $________  SSDI Disabled $________
VA $________  TANF $________
General Assistance $________  Worker’s Compensation $________
Unemployment Insurance $________  Other Disability $________
Other $________

**Medical insurance provider?**

☐ Affordable Care Act Exchange  ☐ Medicaid  ☐ Medicaid Buy-In
☐ Medicare  ☐ No insurance
☐ Not yet eligible for insurance through employer  ☐ Private Insurance through other means
☐ Private insurance through own employment  ☐ Public insurance from other sources
EMPLOYMENT

Date last employed (including year)____________________

Are you requesting services from DVR to maintain employment? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

Work History

Job Title: ________________________________ Start Date: ________ End Date: ______

Employer: __________________________ Employer Address: __________________________

City: __________________________ State: ______ Zip: ______

Job Duties: ____________________________________________________________________________

Hours Worked per Week:______ Salary: $________ per: Hour☐ Week☐ Month☐ Year☐

Reason for leaving ________________________ Could you return to this job?

How does your disability impact this job? ________________________________________________

Was a special license required for this job? ________________________________________________

Could this employer serve as a reference? ________ Name to be used________

Job Title: ________________________________ Start Date: ________ End Date: ______

Employer: __________________________ Employer Address: __________________________

City: __________________________ State: ______ Zip: ______

Job Duties: ____________________________________________________________________________

Hours Worked per Week:______ Salary: $________ per: Hour☐ Week☐ Month☐ Year☐

Reason for leaving ________________________ Could you return to this job? ________

How does your disability impact this job? ________________________________________________

Was a special license required for this job? ________________________________________________

Could this employer serve as a reference? ________ Name to be used________
Division of Vocational Rehabilitation

Job Title: ___________________________________________ Start Date: _______ End Date: _______

Employer: ___________________________ Employer Address: ___________________________

City: _______________________________ State: _____ Zip: _____________

Job Duties:  ________________________________________________________________

Hours Worked per Week:______ Salary: $_________ per: Hour☐ Week☐ Month☐ Year☐

Reason for leaving ______________________________ Could you return to this job? _______

How does your disability impact this job? ________________________________

Was a special license required for this job? ________________________________

Could this employer serve as a reference? __________ Name to be used ________________

Job Title: ___________________________________________ Start Date: _______ End Date: _______

Employer: ___________________________ Employer Address: ___________________________

City: _______________________________ State: _____ Zip: _____________

Job Duties:  ________________________________________________________________

Hours Worked per Week:______ Salary: $_________ per: Hour☐ Week☐ Month☐ Year☐

Reason for leaving ______________________________ Could you return to this job? _______

How does your disability impact this job? ________________________________

Was a special license required for this job? ________________________________

Could this employer serve as a reference? __________ Name to be used ________________

Job Title: ___________________________________________ Start Date: _______ End Date: _______

Employer: ___________________________ Employer Address: ___________________________

City: _______________________________ State: _____ Zip: _____________

Job Duties:  ________________________________________________________________

Hours Worked per Week:______ Salary: $_________ per: Hour☐ Week☐ Month☐ Year☐

Reason for leaving ______________________________ Could you return to this job? _______

How does your disability impact this job? ________________________________

Was a special license required for this job? ________________________________

Could this employer serve as a reference? __________ Name to be used ________________

Veteran Status

☐ Active duty, honorable/general discharge ☐ No Military Service or Dishonorable Discharge
OTHER ITEMS RELATED TO EMPLOYMENT

Education
What is your **highest completed level of education**?

Indicate the name of your program or school where you completed this training:

**Indicate the start date (MM/DD/YR) and end date of this training (MM/DD/YR):**

For any education please list any certifications or diplomas you attained as a result:

Have you ever received services under an IEP (Individualized Education Program) or 504 plan?

Please indicate any current educational enrollment:
Indicate the name of your program or school that you are attending:

Indicate the area of study:

Indicate the start date (MM/YR) of this training:
Indicate the expected graduation date of this training:

If you are currently enrolled in high school are you receiving services under an IEP (Individualized Education Program) or 504 plan?

Other Program Involvement (special programs)
Please list any other community programs or services you are connected with, such as Workforce Centers, Refugee Services, VA, Job Corps, Community Centered Boards, Independent Living Centers, Brain Injury Alliance Center, Youthbuild, etc.:

Disability Information
Please describe your disability:

How do you hope DVR can assist you?
Medical Information

Name of the treatment provider (doctor, psychologist, other) who knows about your disability __________________________

Doctor’s phone: ____________________________ Doctor’s fax: ____________________________

Doctor’s address: ____________________________ Date of last visit: ____________________________

Type of treatment: ____________________________

Reason for treatment: ____________________________

Name of the treatment provider (doctor, psychologist, other) who knows about your disability ____________________________

Doctor’s phone: ____________________________ Doctor’s fax: ____________________________

Doctor’s address: ____________________________ Date of last visit: ____________________________

Type of treatment: ____________________________

Reason for treatment: ____________________________

Name of the treatment provider (doctor, psychologist, other) who knows about your disability ____________________________

Doctor’s phone: ____________________________ Doctor’s fax: ____________________________

Doctor’s address: ____________________________ Date of last visit: ____________________________

Type of treatment: ____________________________

Reason for treatment: ____________________________

Have you ever been hospitalized?

Date of last hospitalization: _____________ What hospital? ____________________________

Reason? ____________________________

Please list prescribed medications and reason prescribed:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Side Effects:

If you’re not currently taking these medications as prescribed, can you share why?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Have drugs and/or alcohol ever impacted your health, interpersonal relationships or employment? ☐ Yes ☐ No

If yes, complete this section: How long have/did you use drugs and/or alcohol? ______

What is the drug of choice? ____________________________ Last date used? ______

Are you willing to receive treatment? ☐ Yes ☐ No
Workers’ Compensation Information (if applicable)

Date of injury __________________________ Attorney __________________________

Phone __________________________ Fax __________________________

Name of the treatment provider (doctor, psychologist, other) who knows about your claim

______________________________

Doctor’s phone: _______________ Doctor’s fax:___________________________
Doctor’s address: _______________ Date of last visit: _______________
Type of treatment: __________________________
Reason for treatment: __________________________

Legal Information

Have you ever been arrested? ☐ Yes ☐ No

If yes, please explain circumstances: __________________________

Current legal status (check all that apply)

Charges Pending ☐ Probation ☐ Parole ☐ Work Release ☐ Community Corrections ☐ Completed Sentence ☐ Other ☐ (describe): __________________________

Please provide an explanation: __________________________

Department of Corrections # (if applicable): __________________________

Probation/parole officer’s name: __________________________

Phone: __________________________

Case manager’s name: __________________________

Phone: __________________________