

Please provide as much information as is known. If you would like assistance with this form, do not hesitate to ask. If you need more space, please use an additional piece of paper. An IVRS representative will contact the applicant within two weeks of receipt of this form to schedule an appointment.

Personal Information:

First Name*: _____ Middle Name: _____ Last Name*: _____

Preferred Name: _____ Maiden or Other Names Used: _____

Home Address: _____

City: _____ State*: _____ Zip*: _____ County*: _____

Home Phone: _____ Cell Phone: _____

May IVRS send text messages? No Yes

Primary E-Mail: _____ Secondary E-Mail: _____

Preferred Method of Communication: E-mail Phone Video Relay Letter

Social Security Number*: _____ Date of Birth*: _____ Age: _____

Do you have a specific low vision impairment that presents difficulty for you in preparing for, obtaining, or maintaining employment; or are you considered legally blind? No Yes

Do you require an interpreter? No Yes Language: _____

Contact Information:

Is there a relative who would usually be able to help us contact you?

First Name: _____ Last Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Is there someone outside of your household who would usually be able to help us contact you?

First Name: _____ Last Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Legal Guardian:

Do you have a court-appointed legal guardian? No Yes (If Yes, please provide name and contact information below.)

Name: _____

Phone: _____ E-Mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Referral Source:

Who referred you to IVRS?

Name: _____ Phone: _____ E-Mail: _____

Address: _____ City: _____ State: _____ Zip: _____

What is the reason they suggested you apply for services? _____

I have been referred because I am currently working in subminimum wage employment or I am considering work at subminimum wage.



STOP HERE--Please send the form to your local IVRS office.

Please bring the following information to the appointment:

Copies of Documents Necessary to Comply With Form I-9, Employment Eligibility Verification.

Driver's License, Social Security Card, Passport, Work VISA, School Record (high school students), etc.

Information about Your Disability

When it started and how it affects your ability to work.

Information about Any Treatment, Past or Present

Medical reports already in your possession, names and addresses of doctors, hospitals, clinics, etc.

Information about Your Education

Names and dates of attendance of high school, college, or vocational schools, etc. Bring grade reports or transcripts if available.

Information about Any Jobs You Have Held

Summary of any work you have done and a copy of your résumé, if you have one

Information about Other Services You Receive

Public Assistance, Social Security Benefits--proof of SSI, SSDI benefit (i.e. check stub, letter of eligibility, etc.), Family Investment Plan (FIP), etc.

IVRS USE ONLY: If low vision question is checked, "yes" send referral to IDB and notify the individual. If the individual does not want to be referred to IDB, notify him/her that IVRS does not serve this population.

Source of Referral *

- | | |
|--|--|
| <input type="checkbox"/> 14(c) Certificate Holders | <input type="checkbox"/> Managed Care Organizations (MCOs) |
| <input type="checkbox"/> Adult Education and Literacy Programs | <input type="checkbox"/> Medical Health Provider |
| <input type="checkbox"/> American Indian VR Services Program | <input type="checkbox"/> Mental Health Provider |
| <input type="checkbox"/> Centers for Independent Living | <input type="checkbox"/> Self-referral, friends or family |
| <input type="checkbox"/> Service Providers including CRPs | <input type="checkbox"/> Social Security Administration |
| <input type="checkbox"/> DOL Adult, Dislocated Worker, and Youth Program | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) |
| <input type="checkbox"/> Elementary/Secondary Schools | <input type="checkbox"/> Veteran's Benefits or Health Administration |
| <input type="checkbox"/> Post-secondary Educational Institutions | <input type="checkbox"/> Wagner-Peyser Employment Service Program |
| <input type="checkbox"/> Employers | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Extended Employment Providers | <input type="checkbox"/> Other Sources |
| <input type="checkbox"/> Intellectual and Developmental Disabilities Providers | <input type="checkbox"/> Other American Job Center or Workforce Development Programs |

Date Received by IVRS: _____

Notes: