

Iowa Vocational Rehabilitation Services
Intake Information

Job Candidate: _____

Case #: _____

Personal Information:

Gender Identity*: Male Female Do not wish to disclose

Preferred Pronoun: he/him she/her they/them other: _____

Marital Status*:

Married, including common law Widowed Divorced Separated Never Married

Living Arrangements*:

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

Number of family members in the household: _____

(IVRS defines "family" as individuals related by blood, marriage, or who reside together as partners.)

Race*: Please check all that apply.

- White Native Hawaiian or Other Pacific Islander Black or African American
 Asian American Indian or Alaska Native Do not wish to disclose

Ethnicity*: Please check one.

Hispanic or Latino No Yes Do not wish to disclose

Voter Registration:

Did the applicant register to vote? No Yes

Disability Information:

What is your disability, condition or diagnosis? _____

How does your disability affect your ability to work or find work? _____

Monthly Support and Benefits*:

If you are receiving public support, please enter whole dollar amounts next to the benefit you receive:

Benefit	Amount	Date Benefit Began
SSDI		
SSI		
TANF		
General Assistance		
Veteran's Disability		
Worker's Compensation		
Unemployment Insurance		
Other Public Support Specify:		

What is your primary source of support*?

- Personal Income (employment earnings, interest, dividends, rent, retirement including SSA retirement)
- Family/Friends Public Support (SSI, SSDI, TANF, etc) All Other Sources

If you are not receiving Social Security disability benefits at this time but have applied, what is the status of your application? Pending Approved/benefits haven't started Denied In appeal

Health Insurance Benefits*:

What source(s) of health insurance do you use? (check all that apply)

- Medicaid Medicaid # _____
- Medicare
- State/Federal Affordable Care Act
- Public Insurance from Other sources (workers' compensation, children's health insurance company, etc.)
- Private Insurance Through My Employer
- Future Eligibility Through My Employer (Date you will become eligible: _____)
- Private Insurance Through Other Means (Health Insurance Company) _____
- No Health Insurance

Managed Care Organization (MCO) Name: _____

Case Manager: _____ Phone Number: _____

Education Information: (Document all credentials earned in IRSS.)

Name and Location of High School: _____

Dept. of Ed. State ID: _ _ _ _ _ Date Enrolled: _____

If still attending, expected graduation date: _____ Graduation* or Drop Date: _____

High School Completion*: Achieved High School Diploma Achieved GED/HiSED

Student with a Disability*: (Must be between 14 and 21 and attending secondary or post-secondary school.)

- Has a section 504 accommodation
- Receiving transition services under an IEP
- Student with a disability, not receiving a 504 accommodation or under an IEP
- Not applicable

If still attending, when (month/year) did you begin special education services? _____

If no longer attending, did you receive special education services while in high school,

Under an IEP? No Yes

Under a 504 plan? No Yes

Do you plan to pursue an education beyond high school? No Yes **If so:**

Have you completed the Free Application for Federal Student Aid (FAFSA)? No Yes

Are you in default of a federal student loan? No Yes

Have you had previous student loans discharged due to a disability? No Yes

Are there any personal problems or circumstances that might interfere with you working or attending school?

No Yes If yes, please explain: _____

Last College or Vocational Training School Attended: _____

School Location: _____ Completed Program? No Yes

If you did not complete the program please explain why: _____

Major or Program: _____ Degree/Certificate Earned*: _____
Start Date: _____ End Date*: _____ GPA: _____

Other College or Vocational Training School Attended: _____
School Location: _____ Completed Program? No Yes

If you did not complete the program please explain why: _____

Major or Program: _____ Degree/Certificate Earned*: _____
Start Date: _____ End Date*: _____ GPA: _____

Military Service*:

Are you a veteran? No Yes Currently Serving

If yes, Type of Discharge: _____

If discharge was dishonorable, please explain: _____

Employment History: *(Used for eligibility/planning purposes only. IRSS should reflect employment at IPE development.)*

Current Employment:

Job Title: _____

Employer: _____

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

Date Began: (Month/Year) _____

Direct Supervisor: _____ Phone: _____

Specific Duties: _____

Wages \$ _____ per _____ Hours Worked: _____ per week

Previous Employment:

Employer: _____ Job Title: _____

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

Date Began: (Month/Year) _____ Date Ended: (Month/Year) _____

Direct Supervisor: _____ Phone: _____

Specific Duties: _____

Reason for Leaving: Change Jobs Further Education Relocated Company went out of business

Laid Off Fired Explain: _____

Other Explain: _____

Will this employer provide a good reference for you? Yes No If no, what do you think the employer will say? _____

Legal History:

Do you have a criminal history? No Yes If yes, describe offenses including dates: _____

Transportation:

What transportation is available to you to get to and from work? _____

Intake Summary Notes:

Expectation of Service:

Disability:

Education/Training:

Employment/Interests:

Personal Supports:

Comments:

Next Steps: