ONLINE APPLICATION FOR REHABILITATION SERVICES
Division of Rehabilitation Services or
Division of Service to the Blind & Visually Impaired

This is part one of a two-part application process. Following submission of this application, a staff member will be reaching out to complete part two of the application process. If we are not able to reach you to complete part two within 60 days of submission, your case will be closed.

Demographic Information:

Legal Name ________________________________ **Preferred Name (if applicable)** ____________________

SSN ______________________________________ **Address**______________________________________

City _____________________ **State** _____________ **Zip** __________ **H-Phone** ___________________

Date of Birth ______________ **County**: ____________ **Email Address** _________________________________

Sex:
- ☐ Male
- ☐ Female
- ☐ Prefer not to Answer

Military Status:
- ☐ Veteran
- ☐ Non-Veteran

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefers to not self-identify

Race (may select more than one):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefers to not self-identify

Current Public Support (May select more than one):
- ☐ Do Not Receive Public Support
- ☐ SSDI
- ☐ SSI
- ☐ TANF
- ☐ Public Support from Another Source

Current Medical Insurance (Choose One):
- ☐ Do Not have Medical Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ State or Federal Affordable Care Act
- ☐ Private Insurance through Own Employer
- ☐ Not Yet Eligible for Private Insurance
- ☐ Private Insurance through Other Means
- ☐ Public Insurance from Other Sources

Source of **Referral (Choose one):**
- ☐ 14(c) Certificate Holders
- ☐ Adult Education and Family Literacy Act Program
- ☐ American Indian VR Services Program (AIVRS)
- ☐ Centers for Independent Living
- ☐ Service Provider
- ☐ Adult/Dislocated Worker/Youth Program
- ☐ Elementary and Secondary Schools
- ☐ Post-secondary Education Institutions
- ☐ Employers
- ☐ Extended Employment Providers
- ☐ Intellectual and Developmental Disability Agencies
- ☐ Medical Health Providers
- ☐ Mental Health Providers
- ☐ Self-referral, friends, family
- ☐ Social Security Administration
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Veteran's Benefits or Health Administration
- ☐ Wagner-Peyser Act Employment Service Program (Title III of WIOA)
- ☐ Worker's Compensation
- ☐ Other Sources
- ☐ Other American Job Center or Workforce Development Programs

Student Status:

Current High School student: ☐ Yes ☐ No

If yes, are you on a:

☐ 504

☐ IEP

☐ Not on a 504 or IEP

If no, were you previously on an IEP or 504?

☐ Yes ☐ No

Current/Highest Grade Level Achieved ____________

Anticipated Graduation Date____________________

Current/Previous High School__________________

Other Questions:

Current Living Arrangement (Private Residence, Group Home, Correctional Facility, Halfway House, Homeless/Shelter, Mental Health Facility, Nursing Home, Rehab Facility, Substance Abuse Treatment, Other.):____________________

Marital Status (Divorced, Married, Never Married, Separated, Widowed): ________________________________

Primary Source of Support (Wages, Public Assistance, Friend/Family, etc.): ______________________________

Do you have a visual impairment-aside from wearing glasses or contacts-that significantly impacts your ability to work such as Macular Dystrophy, Glaucoma, Cataracts, or others? ____

Name and phone number of legal guardian (if applicable): ____

Disclosures:

I wish to apply for vocational rehabilitation services that will result in employment. I understand that my eligibility for services will be determined within 60 days unless I receive trial work/extended evaluation or grant an extension. I also authorize the division to gather and release information to determine my eligibility for rehabilitation services and to assist in determining the services necessary which will lead to my employment.

The exchange of information may include cooperating with other departments in state government, the Social Security Administration, local school districts, and other agencies involved in Workforce Development. Information may also be released to potential employers to assist in my placement in employment. I further authorize the Division to release/supply to the Department of Human Services and their divisions, the following information: name, social security number, date of birth, race, sex, demographic data, and program status. This information is necessary for the purpose of collecting, reporting, analyzing data and to facilitate access to services/programs offered by the Department of Human Services. Other than these situations, information will only be released to sources upon my individual written consent. I understand that I may restrict the release of information. Requested restrictions and/or comments:

I have been given access to information on the Client Assistance Program at this link https://dhs.sd.gov/servicetotheblind/docs/LargeprintCAP.pdf . If I am dissatisfied with any action regarding my eligibility or denial of services, I understand I may request in writing within 30 days of the eligibility decision or denial of services for an administrative review, mediation or a fair hearing to:

Assistant Director for the
Division of Rehabilitation Services or Division of Service to the Blind and Visually Impaired
East Highway 34, % 500 East Capitol
Pierre, SD 57501-5070

I acknowledge that the information in this form has been presented to me in a format that I can understand, and I will be provided a copy of my application at my request. I declare and affirm under the penalties of perjury that the information I provided during intake and case services is true and correct to the best of my knowledge and ability. I also acknowledge it is my responsibility to report any significant changes that would affect my vocational rehabilitation plan as soon as possible.

____ _____________

Signature of Applicant or Authorized Representative **Application Date**

____ _______________

Signature of Legal Guardian **Application Date**