DHS-VR-302 6/12

APPLICATION FOR REHABILITATION SERVICES

Division of Rehabilitation Services or Division of Service to the Blind & Visually Impaired

Name _____ **SSN** _____

Address _____ **City** _____

State _____ **Zip** _____ **H-Phone** _____ **Date of Birth** _____

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 received a brochure and explanation concerning the Client Assistance Program. If I am dissatisfied with any action in regards to 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 have been provided a copy of my application. 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**