

ONLINE APPLICATION FOR REHABILITATION SERVICES

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

Demographic Information:

Name _____ SSN _____

Address _____ City _____ State _____

Zip _____ H-Phone _____ Date of Birth _____ County: _____

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

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

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

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, etc.): _____

Marital Status: _____

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? _____

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