

# APPLICATION FOR REHABILITATION SERVICES

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

**Name** \_\_\_\_\_ **SSN** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

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 access to an information sheet explaining the Client Assistance Program. If I am dissatisfied with any action in regard to my eligibility or denial of services, I understand I may submit a 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**  
**Assistant Director for the Division of Service to the Blind and Visually Impaired**  
**East Highway 34, c/o 500 East Capitol**  
**Pierre, SD 57501-5070**

I acknowledge that this form is in a format that I can understand, and that I have accessed and completed this form electronically. A copy of this form will be provided upon request. I declare and affirm under the penalties of perjury that the information I provide during intake and case services will be 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. Please print, sign, and mail to the address listed above.

\_\_\_\_\_  
**Signature of Applicant or Authorized Representative**

\_\_\_\_\_  
**Application Date**

\_\_\_\_\_  
**Signature of Legal Guardian**

\_\_\_\_\_  
**Application Date**