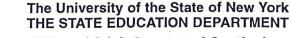
## Please return the completed form to:



Office of Adult Career and Continuing **Education Services (ACCES-VR)** 

## Application for VR Services

Please print or type all entries VR-04 (2/11) SEX Middle Initial NAME First Male **Female** Middle initial Last **First** If your school, health, or any other records are fisted under another name, then enter the name(s) here: Apartment Number **MAILING ADDRESS SOCIAL SECURITY NUMBER** County City ZIP + 4 Code State DATE OF BIRTH Best time to call PHONE NUMBER(s) where we can reach you or leave a message Month Day Year 2. ( 1. ( Area Code 2. Area Code American Indian or Alaska Native ☐ Hispanic or Latino Race/Ethnicity - Choose ALL that apply. If left ■ Native Hawaiian or Other Pacific Islander Asian (Includes Indian Subcontinent) blank ACCES will complete. If Hispanic or Latino White Black or African American is checked please check additional box. Who referred you to us? MARITAL STATUS 1 Married 3 Divorced What is your disability? 2 Widowed 4 Separated 5 Never Married I hereby apply for rehabilitation services: Signature of applicant, parent, or legal guardian Date  $oldsymbol{X}$  (sign. here) • • • Please answer the questions below and on the back of this form. • • • While you do not have to answer these questions now, your answers will help ACCES-VR process your application. Have you ever received services from ACCES-VR or its former name, the Office of Vocational If you are, indicate the name(s) and address(es) Describe how your disability limits your ability to work. What services are you seeking from ACCES-VR?

Are you disabled bed	cause of a work-rela	ated injury?	☐ Yes	☐ No	Check the	SSI		SSDI
Do you use any assistive devices or aids?			Yes	☐ No	benefit(s) yo now receive		s   nsation	Other
Do you have a valid driver's license?			Yes	· No	Do you regularly see a doctor Yes Notes or clinic about your disability?			
Do you have access to a motor vehicle?			Yes	☐ No				
Do you use public transportation?			Yes	☐ No				
Are you able to leave your home?  Are you able to leave your home?  Also, if you see one or more do clinics about your disability, list below their names and address							ty, list in	the box
Name and address of doctor(s) and clinic(s)								- 4
		•••••••	••••••					
Circle the highest grade you have successfully completed, and check the applicable box(es)								
1 2 3 4 5 6 7 8 Elementary	9 10 11 12 G High School E	ED, or High quivalency	School Diploma		13 14	15 16 1 lege One d Years	7 or More	20 Doctorate
Special Education	Yes No	Do you not high	w attend school?	Yes	No Indicate	college degree(s)	earned	
Name and address of school you last attended								
List below other people in your household  Eull Name Age Their Relationship to You								
	Full Na	ame		-	Age	Ineir Reia	uonsni	o to you.
	· .							
List below the person or persons ACCES-VR can contact in an emergency								
Name			Add	Iress			Pho	ne
	PROJECT STORY OF THE STORY OF T						,	
					*		-	
List below your work history (include attachments, as necessary)								
		ate Emplo	yed	Wee	kly	Job title an Reason	ACC は ACC は 200 12 12 12 12 12 12 12 12 12 12 12 12 12	PROPERTY OF THE PROPERTY OF TH
Employer Name an	d Address	From T	O	Earni	ngs	neason	ioi Eca	/mg
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All information will be kept confidential and is subject to verification

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