State of Hawaii
Department of Human Services
Division of Vocational Rehabilitation (DVR)

Application for Vocational Rehabilitation Services

Hawai'i Division of Vocational Rehabilitation (DVR) provides services to community members who experience barriers to employment due to a functional, psychological, developmental, cognitive, or emotional disability. The DVR program is designed to assist job seekers with disabilities to prepare for, secure, advance and retain competitive employment in an integrated work setting.

Personal Information

Date of Birth:	SS#:	
Last Name:	First Name:	MI:
Previous Name:	Preferred Name:	
Address:	City:	
State/Zip:	County	
Phone Number:	E-mail Address:	
Preferred Method of Contact: ☐ Voice ☐ Text ☐ Fax ☐ Video Phone ☐ TTY ☐ Email		
Gender: ☐ Male ☐ Female ☐ Do Not Wish to Self-Identify		
Marital Status: ☐ Single/Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Veteran: ☐ Yes ☐ No	Primary Language:	
Registered to Voter: ☐ Yes ☐ No	If you are eligible to vote, would you like to register to vote? ☐ Yes ☐ No	

Relative Contacts *(Optional)*

Name:		Relationship:
Phone:	Email:	
Name:		Relationship:
Phone:	Email:	

Races/Ethnicities:

☐ African American or Black	☐ American Indian or Alaskan Native	☐ Hispanic or Latino
☐ Filipino	☐ Native Hawaiian	☐ White
☐ Marshall Islands ☐ Micronesia ☐ Palau ☐ Samoa ☐ Tongan ☐ Other Pacific Islander		
☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian		☐ Do Not Wish to Self-Identify

Disability

What is your disability? Please check all that apply.		
☐ Behavioral Health	☐ Blind or Visually Impaired	☐ Cognitive Delay
☐ Deaf or Hard of Hearing	☐ Developmental Delay	☐ Other:
Please describe your disability:		
Do you use any assistive devices or aids? ☐ Yes ☐ No		If yes, what kind?
Are you disabled because of a work-related injury? ☐ Yes ☐ No		

Describe how your disability limits your ability to work:

Accommodations

☐ Foreign Language Interpreter	Language:	
☐ American Sign Language Interpreter		
☐ Braille	☐ Reader	☐ Large Print
☐ Other- please explain:		
☐ N/A		

Medical Insurance Information

☐ None	☐ Not available for collection	
☐ Medicaid (Includes QUEST)	☐ Medicare	
☐ Private insurance through employer	☐ Private insurance through other means	
☐ Not yet eligible for private through employer	☐ Public insurance (e.g. worker's compensation)	
☐ State/Federal Affordable Care Act Exchange	☐ Other:	
Primary Insurance Carrier:	Policy Number:	
Secondary Insurance Carrier:	Policy Number:	
Medicaid Number:	Medicare Number:	
Do you regularly see a doctor or clinic about your disability? ☐ Yes ☐ No		How often?
Please provide the name and address of doctor(s) and clinic(s):		

Household Information

☐ Private Residence (by yourself, with family or others)	☐ Substance Abuse Treatment Center
☐ Adult/Youth Correctional Facility	☐ Mental Health Facility
☐ Community Residential/Group Home	☐ Nursing Home
☐ Homeless Shelter	☐ Rehabilitation Facility
☐ Halfway House	☐ Other (specify):
Number in Family:	Number of Dependents:

Financial Income and Public Assistance (enter currency in categories)

☐ None	
☐ Supplemental Security Income (SSI)	$
☐ Social Security Disability Insurance (SSDI)	$
☐ Temporary Assistance for Needy Families (TANF)	$
☐ Supplemental Nutrition Assistance Program (SNAP)	$
☐ Veteran Disability Benefits (VA)	$
☐ Unemployment Insurance (UI)	$
☐ Worker's Compensation (WC).	$
If you are receiving WC, are you receiving VR services from a private VR agency? ☐ Yes ☐ No	
☐ General Assistance (GA)	$
☐ Private Income Source	$
☐ Other:	$

Legal Representative

Do You Have a Legal Guardian: ☐Yes ☐No	If Yes, Name:
Address:	City/State/Zip:
Phone Number:	E-mail Address:

Student with a Disability

☐Not a student
☐Student in Middle or High School with a 504 Plan
☐Student in Middle or High School with an Individualized Education Program (IEP)
☐Student in Middle or High School with No Individualized Education Program (IEP) and No 504 Plan
☐Student in Post-Secondary Education or Other Education Program 21 or Under
☐Student in Post-Secondary Education or Other Education Program 22 or Over
Name of School:

Education *(Enter name of school and select highest level completed)*

	Grade School: ☐Fifth Grade ☐Sixth Grade ☐Seventh Grade ☐Eight Grade
	High School: ☐Freshman ☐Sophomore ☐Junior ☐Senior
	College: ☐Freshman ☐Sophomore ☐Junior ☐Senior
	Advanced: ☐Masters ☐Ph.D.

Authority to Legally Work

United States Citizen: ☐Yes ☐No	Legal Status to Work in the US? ☐Yes ☐No
Hawaii Driver's License: ☐Yes ☐No	Hawaii Identification Card: ☐Yes ☐No

Employment

Currently Employed: ☐Yes ☐No ☐Requesting Services to Obtain Employment.
☐Requesting Services to Maintain Employment.

Work History *(List previous employers starting with most recent)*

Employer:	Job Title:
Start Date:	End Date:
Leave Reason:	
Employer:	Job Title:
Start Date:	End Date:
Leave Reason:	
Employer:	Job Title:
Start Date:	End Date:
Leave Reason:	

Job Interests

Job Title:	Why:
Job Title:	Why:

Referral Information

☐ Self-referral	☐ Family/friend	☐ American Job Center	
☐ Development Disabilities Division	☐ Veteran Affairs	☐ Wagner-Peyser	
☐ Centers for Independent Living	☐ Child Protective Services	☐ Another State VR Agency	
☐ Department of Education Adult Education	☐ Department of Labor & Industrial Relations		
☐ Other:			
Referral Source (if applicable)			
Agency:	Representative:	Phone:	E-mail:
Are you involved with another Agency/Organization/Program? ☐ Yes ☐ No			If yes, please list below:
Agency:	Representative:	Phone:	E-mail:
Agency:	Representative:	Phone:	E-mail:
Have you been involved with a DVR Program before? ☐ Yes ☐ No			If yes, please list where/when:
Where:	When:		
What services are you seeking from DVR?			

Information Before You Sign

DVR services will be provided without discrimination based on sex, race, age, creed, disability, or national origin as prohibited by the Civil Rights Act, Age Discrimination Act, and the Rehabilitation Act, as amended. I have the right to request for a formal hearing with the local or federal Civil Rights Office within 180 days of any decision or action which I believe is based on my sex, race, age, creed, disability, or national origin. If I am dissatisfied with any decision or action taken by the division based on other reasons than discrimination, I have the right to request for a review within 90 days of such decision or action, through Mediation or Fair Hearing. The Client Assistance Program is available should I need assistance or advice in working with the division.

The division has a need to collect personal information about me to determine my eligibility for services as authorized by the Rehabilitation Act as amended, and that all information about me will be kept confidential. I understand that providing this information is voluntary on my part, but that the division may be unable to serve me without the requested information.

I understand that in order for the division to determine my eligibility for services and when necessary to provide me with rehabilitation services, the requested information may be routinely released, without my written informed consent, to physicians, psychologists, therapists, nurses, clinics, hospitals, public agencies, schools and other training institutions or programs, employers, and other private, non-profit agencies serving person with disabilities, and that such information shall otherwise be kept confidential and not released for any other purposes than for administering my vocational rehabilitation program, without my written informed consent.

I understand the purpose of receiving vocational rehabilitation services is to enable me to obtain or retain employment. I understand that I must be available to take part in the assessment process and be determined eligible before I can receive any services that I require. With this application, I am applying for vocational rehabilitation services because I want to work.

Verification of Accuracy

I declare that the information provided on this Application for Vocational Rehabilitation Services is true and accurate. I agree to meet with a Qualified Vocational Rehabilitation Specialist for an Intake Interview to complete the application process.	
Signature:	**Date:**
Legal Representative (If applicable)	**Date:**
Assisted applicant with completion of this application: ☐ Yes ☐ No	
Signature:	**Date:**

Please submit form via mail, fax or hand delivery to the Hawaii Division of Vocational Rehabilitation (DVR) Branch nearest you. DVR will contact you soon to meet with a Qualified Vocational Rehabilitation Specialist to review this form during an intake interview and learn more about the DVR process, rights & responsibilities, how to appeal decisions made by DVR, and the Client Assistance Program.

O'ahu Branch (HNL) 600 Kapiolani Blvd, #305 Honolulu, HI 96813 Ph: (808) 586-4824 (V/T) Fax: (808) 586-4833	Kapolei Office 601 Kamokila Blvd, #515 Kapolei, HI 96707 Ph: (808) 692-8603 (V/T) Fax: (808) 692-8616	Services for the Blind Branch 1901 Bachelot Street Honolulu, HI 96817 Ph: (808) 586-5269 (V/T) Fax: (808) 586-5388
Maui Branch 54 So. High St, #309 Wailuku, HI 96793 Ph: (808) 984-8350 (V/T) Fax: (808) 984-8355	Moloka'i Section 55 Makaena St, # 3 Kaunakakai, HI 96748 Ph: (808) 553-3621 (V/T) Fax: (808) 553-5048	Kaua'i Branch 3060 Eiwa St. #304 Lihue, HI 96766 Ph: (808) 274-3333 (V/T) Fax: (808) 274-3340
Hawai'i Branch 75 Aupuni St, Rm 110 Hilo, HI 96720 Ph: (808) 974-6444 (V/T) Fax: (808) 974-6450	Kona Section 75-5722 Kuakini Hwy, Ste 213 Kailua-Kona, HI 96704 Ph: (808) 323-0025 (V/T) Fax: (808)	

For Division of Vocational Rehabilitation Use Only
Case Information

Referral Date (date entered in AWARE) _____
Application Date (date entered in AWARE) _____
Received By _____
Intake Interview Date _____

Applicant	Case ID	VRS Assigned	Section	Case Status
☐ New PE Case				
☐ New VR Case				
☐ Active PE Case				
☐ Active VR Case				
☐ Previous Closure				