pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF VOCATIONAL REHABILITATION

OVR PRE-APPLICATION

Reset Form | Print Form

PID: CID:

The Pennsylvania Office of Vocational Rehabilitation (OVR) helps individuals with disabilities prepare for, obtain, or keep suitable employment.

TO BE ELIGIBLE FOR OVR SERVICES YOU MUST:

1. Have a disability that causes a substantial impediment to employment
2. Need services from OVR to achieve employment, and
3. Be able to benefit from services in terms of an employment outcome.

CONFIDENTIALITY

All medical and personal information shall be held as confidential. Use of such information will be limited to purposes directly connected with your rehabilitation program.

*** Indicates Required Field - Please complete each question to the best of your knowledge and ability.**

PERSONAL INFORMATION

APPLICATION DATE	* FIRST NAME	MI	* LAST NAME	SUFFIX	MAIDEN OR OTHER NAME

* LOCATION ADDRESS	* CITY	* STATE	* ZIP CODE	* COUNTY
* MAILING ADDRESS ☐ SAME AS ABOVE	* CITY	* STATE	* ZIP CODE	* COUNTY

*** CORRESPONDENCE PREFERENCE**

☐ Email ☐ Mail

*** GENERAL CONTACT PREFERENCE**

☐ Location Address ☐ Primary Phone ☐ Cell Phone ☐ Email
☐ Mailing Address ☐ Work Phone ☐ Fax Number ☐ Video Phone

EMAIL ADDRESS	PRIMARY PHONE	WORK PHONE	CELL PHONE	VIDEO PHONE
	☐ TDD/TTY	☐ TDD/TTY		

FAX NUMBER

LANGUAGE PREFERENCE

☐ English
☐ Spanish
☐ Other: _____

ADDITIONAL COMMUNICATION NEEDS

☐ Foreign Language Interpreter ☐ Braille
☐ Sign Language Interpreter ☐ Large Print
☐ Other: _____

CONTACT PERSON FIRST NAME	CONTACT PERSON LAST NAME	RELATIONSHIP TO CONTACT PERSON	CONTACT PERSON PHONE

SSN

*** GENDER**

☐ Male
☐ Female

*** DATE OF BIRTH**

*** CITIZENSHIP STATUS**

☐ US Citizen ☐ Refugee ☐ Non-US Citizen
☐ Permanent Alien ☐ Illegal Alien ☐ Unknown
☐ Temporary Alien

CAN YOU LEGALLY WORK IN THE U.S.?

☐ Yes
☐ No
☐ Don't Know

*** ETHNICITY**

☐ Hispanic/Latino
☐ Non-Hispanic/ Latino
☐ Do not wish to disclose

*** RACE**

☐ American Indian or Alaskan Native ☐ Hawaiian Native/Other Pacific Islander
☐ Asian ☐ White
☐ Black/African American ☐ Do not wish to disclose

*** WHO REFERRED YOU TO OVR?**

CUSTOMER: **PID:** **CID:**

OTHER PERSONAL INFORMATION (CONTINUED)

*** ARE YOU A VETERAN?**

☐ Yes ☐ No

*** IF A VETERAN, IS YOUR DISABILITY SERVICE CONNECTED?** ☐ Yes ☐ No

*** IF YES, PERCENTAGE OF DISABILITY** _____ **%**

IF A VETERAN, ARE YOU ELIGIBLE FOR VA VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICES? ☐ Yes ☐ No

*** VOTER REGISTRATION – OVR can help you register to vote. You are not required to register. Please select one of the following:**

☐ I would like OVR to provide me with a Voter Registration Application, which I will complete and submit myself
☐ I would like OVR to help me complete and submit a Voter Registration Application
☐ I am already registered to vote
☐ I am not registered to vote and do not wish to register
☐ I am not registered to vote because I am under the age of 18
☐ I am not registered to vote because I am not eligible

EDUCATION INFORMATION

*** ARE YOU A STUDENT?**

☐ Yes ☐ No

*** IF A STUDENT, SELECT ONE OF THE FOLLOWING THAT APPLIES TO YOU**

☐ I am a student in high school with a 504 accommodation plan
☐ I am a student in high school with an Individualized Education Plan (IEP)
☐ I am a student in high school who does not have a 504 accommodation plan or an IEP
☐ I am a student in postsecondary education

*** IF A STUDENT, LIST YOUR ANTICIPATED GRADUATION DATE OR ANTICIPATED DATE OF COMPLETION**

DISABILITY AND EMPLOYMENT INFORMATION

Please complete to the best of your ability. If you are unsure how to answer a question, you will have the opportunity to review your answers with an OVR counselor during your initial meeting. Please bring any medical information or records you have to your initial interview. Having this information up front can reduce the length of time it takes to determine your eligibility for OVR services.

*** WHAT IS YOUR DISABILITY (OR DISABILITIES)?**	*** YEAR OF ONSET**	*** ARE YOU CURRENTLY EMPLOYED?** ☐ Yes ☐ No

*** HOW CAN OVR HELP YOU TO GET, KEEP, OR ADVANCE IN A JOB?**

*** WHAT JOBS OR CAREERS INTEREST YOU? COMPLETE TO THE BEST OF YOUR ABILITY. YOU MAY WRITE "UNKNOWN" IF YOU DO NOT HAVE A CAREER INTEREST AT THIS TIME.**

HOUSEHOLD INFORMATION

*** SELECT THE OPTION WHICH BEST DESCRIBES YOUR CURRENT LIVING ARRANGEMENT OR PLACE OF RESIDENCE, WHETHER PERMANENT OR TEMPORARY**

☐ Private Residence (independent or with family/other person)
☐ Community Residential/Group Home
☐ Rehabilitation Facility
☐ Mental Health Facility
☐ Nursing Home
☐ Adult Correctional Facility
☐ Halfway House
☐ Substance Abuse Treatment Center
☐ Homeless/Shelter
☐ Other

CUSTOMER: **PID:** **CID:**

HOUSEHOLD INFORMATION (CONTINUED)

*** WHAT IS YOUR CURRENT MODE(S) OF TRANSPORTATION? (Select all that apply)**

- ☐ Personal vehicle (with driver's license)
- ☐ Personal vehicle (no driver's license)
- ☐ Public transportation
- ☐ Friends and/or relatives
- ☐ Shared ride service
- ☐ Paratransit
- ☐ None, I currently cannot get around my community
- ☐ Other (Please explain) _____

*** WHAT IS YOUR PRIMARY SOURCE OF SUPPORT?**

- ☐ Personal Income (employment earnings, interest, dividends, rent, retirement including social security)
- ☐ Family and Friends
- ☐ Public Support (SSI, SSDI, TANF, etc.)
- ☐ All other sources (e.g., private disability insurance and private charities)
  - * For all other sources, please specify: _____

*** IF YOU ARE RECEIVING PUBLIC SUPPORT, SELECT EACH TYPE YOU ARE RECEIVING. (Select all that apply)**

- ☐ Supplemental Security Income (SSI)
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Veteran's Disability Benefits
- ☐ Worker's Compensation
- ☐ *Other Public Support
- ☐ Unemployment Insurance

**Other public support may include any cash payments you receive beyond those listed. Please include payments made by Federal, State and Local Governments for retirement or survivor benefits, as well as any temporary public support payments you are currently receiving outside of those already listed.*

WAIVER SERVICES AND OTHER AGENCY INVOLVEMENT

*** ARE YOU CURRENTLY RECEIVING MEDICAL ASSISTANCE (MA) WAIVER SERVICES FROM THE PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES?**

☐ Yes ☐ No – *If no, skip to Other Agencies section below*

*** MA WAIVER SERVICE AGENCY AND TYPE**

1. Office of Developmental Programs – Intellectual Disabilities
   - ☐ Consolidated
   - ☐ Personal/Family Directed Services (P/FDS)
2. Office of Developmental Programs – Autism
   - ☐ Adult Autism
   - ☐ Adult Community Autism Program (ACAP)
3. Office of Long Term Living
   - ☐ COMMCARE (TBI)
   - ☐ OBRA (Dev Disabilities not ID/Autism)
   - ☐ Independence (Physical Disabilities)
   - ☐ Attendant Care

SUPPORT COORDINATOR/MA CASE MANAGER	SUPPORT COORDINATOR/MA CASE MANAGER PHONE	SUPPORT COORDINATOR/MA CASE MANAGER EMAIL

OTHER AGENCIES - List any <u>other</u> agencies, facilities, rehabilitation programs, or law enforcement agencies from which you are currently receiving or previously received services.

* AGENCY OR PROGRAM NAME	SERVICES RECEIVED	POINT OF CONTACT	CONTACT PHONE &/OR EMAIL

CUSTOMER: **PID:** **CID:**

MEDICAL INFORMATION

*** PLEASE SELECT EACH TYPE OF INSURANCE THAT YOU CURRENTLY HAVE**

- ☐ Medicaid
- ☐ Medicare
- ☐ Medical Assistance for Workers with Disabilities (MAWD)
- ☐ Public Insurance from Other Sources
- ☐ State or Federal Affordable Care Act Exchange
- ☐ Private insurance through employer
- ☐ Not yet eligible for private insurance through employer
- ☐ Private insurance through other means
- ☐ I currently do not have medical insurance

*** ARE YOU AN INDIVIDUAL WITH BLINDNESS OR A VISUAL IMPAIRMENT?**

☐ Yes ☐ No *(If NO, skip to Medical Conditions below)*

IF YES, WHAT IS YOUR VISUAL ACUITY (WITH BEST CORRECTION)

- ☐ 20/20 – 20/69
- ☐ 20/200 or greater
- ☐ 20/70 – 20/199

VISUAL FIELDS

- ☐ Normal
- ☐ Restricted 20 degrees or less
- ☐ Somewhat Restricted
- ☐ Unknown

HOW IS YOUR EYE CONDITION TREATED?

HAVE YOU HAD VISION SERVICES BEFORE?

☐ Yes ☐ No

IF YOU HAD VISION SERVICES BEFORE, WHAT KIND AND WHERE?

MEDICAL CONDITIONS - PLEASE SELECT ALL CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST, AS WELL AS THOSE YOU ARE CURRENTLY EXPERIENCING

- ☐ Alcohol addiction
- ☐ Amputations
- ☐ Anxiety
- ☐ Arthritis
- ☐ ADHD
- ☐ Asthma or allergies
- ☐ Autism
- ☐ Blindness
- ☐ Blood disorders
- ☐ Cancer
- ☐ Cardiac (heart) problems
- ☐ Cerebral palsy
- ☐ Congenital condition
- ☐ Cognitive disability
- ☐ Cystic fibrosis
- ☐ Deafness
- ☐ Deaf-blindness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive problems
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ End stage renal failure
- ☐ Epilepsy
- ☐ Hard of hearing
- ☐ HIV/AIDS
- ☐ Immune deficiencies
- ☐ Injury resulting in change or loss of limb function
- ☐ Intellectual disability
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson's disease or other neurological disorders
- ☐ Personality disorder
- ☐ Physical disability
- ☐ Polio
- ☐ Respiratory disorder
- ☐ Schizophrenia
- ☐ Specific learning disability
- ☐ Spinal cord injury
- ☐ Stroke
- ☐ Traumatic brain injury
- ☐ Vision impairment

Please select any areas that make it difficult for you to get, keep, or advance in a job as a result of your disability/disabilities. At least one item in this section must be marked.

MOBILITY (Moving efficiently from place to place)

- ☐ Walking
- ☐ Driving
- ☐ Using public transportation
- ☐ Climbing stairs
- ☐ Requires a brace, cane, or other device
- ☐ Requires a wheelchair

SELF CARE (Skills needed to fulfill basic needs related to health, safety, hygiene and financial management)

- ☐ Living on your own (without supervision)
- ☐ Toileting
- ☐ Dressing
- ☐ Taking medication on your own
- ☐ Money management
- ☐ Eating
- ☐ Grooming
- ☐ Hygiene
- ☐ Housekeeping

WORK TOLERANCE (Carrying out physical and/or cognitive work tasks in an efficient and effective manner over a sustained period of time)

- ☐ Weakness/pain in arms/hands
- ☐ Stamina
- ☐ Stress
- ☐ Weakness/pain in legs/feet
- ☐ Noises/vibrations
- ☐ Strength
- ☐ Sitting, standing, bending
- ☐ Working a full shift
- ☐ Balance
- ☐ Concentrating for several hours
- ☐ Temperature changes
- ☐ Chemicals
- ☐ Light/visual stimuli
- ☐ Fumes/dust
- ☐ Numbness

CUSTOMER: **PID:** **CID:**

MEDICAL INFORMATION (CONTINUED)

INTERPERSONAL SKILLS (Effectively interacting with others)

- ☐ Getting along with others
- ☐ Accepting supervision
- ☐ Cooperation
- ☐ Controlling emotions
- ☐ Understanding social cues
- ☐ Maintaining eye contact
- ☐ Participating in activities due to feeling withdrawn, anxious, or isolated

WORK SKILLS (Critical skills needed to carry out essential work functions such as functional academics, motor skills, processing speed, memory, and communication)

- ☐ Identifying/Counting Money
- ☐ Learning New Tasks
- ☐ Memory
- ☐ Reading Instructions
- ☐ Motor Coordination
- ☐ Speed
- ☐ Hand/Eye Coordination
- ☐ Time Management
- ☐ Attention

COMMUNICATION (Accurately and efficiently transmitting or receiving information verbally or non-verbally)

- ☐ Requires Assistive Device(s) to Communicate
- ☐ Speaking
- ☐ Writing
- ☐ Interviewing
- ☐ Reading
- ☐ Hearing

SELF-DIRECTION (Planning, initiating, and monitoring behavior with respect to a desired outcome that serves to benefit the individual)

- ☐ Learning Consequences to Actions
- ☐ Making Decisions on Your Own
- ☐ Being Organized
- ☐ Require Assistive Device for Planning, Organizing, Etc.
- ☐ Being On Time
- ☐ Problem Solving
- ☐ Adjusting to New Conditions
- ☐ Planning Activities

PLEASE ENTER COMMENTS TO BETTER EXPLAIN THE ABOVE INFORMATION OR TO ADD ADDITIONAL INFORMATION

MEDICAL PROFESSIONAL(S) TREATING YOUR DISABILITY (DISABILITIES)

MEDICAL SPECIALIST #1

SPECIALIST NAME	ADDRESS	CITY	STATE	ZIP CODE

DATE OF LAST APPOINTMENT

TYPE OF MEDICAL PROFESSIONAL

- ☐ Family Doctor
- ☐ Psychiatrist
- ☐ Specialist
- ☐ Therapist
- ☐ Health Care Provider
- ☐ Hospital
- ☐ Treatment Facility
- ☐ Optometrist/Ophthalmologist

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MEDICATIONS

NAME	REASON	SIDE EFFECTS (IF APPLICABLE)