Maryland State Department of Education
Division of Rehabilitation Services
www.dors.maryland.gov
APPLICATION for REHABILITATION SERVICES

Referral Information
Social Security Number: ______________ **Birth Date:** ______________
Name (Last, First, Middle): ______________
What do you prefer to be called? ______________
Please list any previous last names (e.g. maiden name, etc.): ______________
Who referred you to DORS? ______________

Home Address (house number and street address, apt., etc.): ______________
City: ______________ **State:** ______________ **Zip Code:** ______________
County: ______________
Mailing Address:(if different from home address) ______________
City: ______________ **State:** ______________ **Zip Code:** ______________
County: ______________
Phone: ______________ ☐ Home ☐ Cell Phone ☐ Fax ☐ TDD ☐ Videophone ☐ Work
Second Phone: ______________ ☐ Home ☐ Cell Phone ☐ Fax ☐ TDD ☐ Videophone ☐ Work
Email Address: ______________

What is your living arrangement? ☐ Private Residence (independently or with family or other person)
☐ Community Residential Facility or Group Home ☐ Rehabilitation Facility ☐ Mental Health Facility
☐ Nursing Home ☐ Correctional Facility ☐ Halfway House ☐ Substance Abuse Treatment Center
☐ Homeless/Shelter ☐ Other Arrangement: ______________

Emergency or Other Contacts:
Name: ______________ **Relationship:** ______________
Phone/TDD: ______________ **Email:** ______________
Name: ______________ **Relationship:** ______________
Phone/TDD: ______________ **Email:** ______________

Characteristics
Gender: ☐ Male ☐ Female ☐ I do not wish to self-identify
Please identify your race/ethnicity (check all that apply):
☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ I do not wish to self-identify (this is an option for individuals who are not enrolled in secondary school)
Are you Hispanic or Latino? ☐ Yes ☐ No

Do you need assistance with communicating in English? ☐ Yes ☐ No
Please explain: ______________
Do you need assistance with reading English? ☐ Yes ☐ No
Please explain: ______________

What is your primary language?
☐ English ☐ Chinese ☐ Korean ☐ Russian ☐ Spanish ☐ Vietnamese
☐ American Sign Language (ASL) ☐ Contact Signing/PSE ☐ Signed Exact English ☐ Foreign Sign Language
☐ Speech Reading ☐ Tactile Communication ☐ Other: ______________

How would you prefer to receive written communication?
☐ Standard Print ☐ Braille ☐ Large Print ☐ Electronic Format/E-mail ☐ Audio Recording

If you would like DORS staff to send job leads, appointment reminders, schedule changes and other updates to you by text message, please indicate your cell phone number and cell phone service provider/carrier:
Cell Phone Number:______________
Provider: ☐ AT&T ☐ Alltel ☐ Boost Mobile ☐ Cricket ☐ Metro PCS ☐ Net10 ☐ Sprint PCS ☐ Straight Talk
☐ T-Mobile ☐ TracFone ☐ US Cellular ☐ Verizon ☐ Virgin Mobile ☐ Other: ______________

To obtain this Application in Braille, in large print, on disk or in other format, see your DORS counselor or call 1-888-554-0334.

Are you a U.S. Citizen? ☐ Yes ☐ No **If not, are you authorized to work in the U.S.?** ☐ Yes ☐ No

Employers by law must require all new hires to fill out a federal I-9 “Employment Eligibility Verification” form based on certain forms of I.D. Which of the following forms of ID do you currently possess for I-9 verification? Check all that apply:

☐ U.S. Passport ☐ Driver's License ☐ State/Government-issued ID Card ☐ U.S. Military ID
☐ Permanent Resident Card (“Green Card”) – Alien Registration Number: ____________________ Expiration: _______
☐ Social Security Card ☐ Birth Certificate ☐ None

If you have no I.D., have you applied for I.D.? ☐ Yes ☐ No

Veteran Status

☐ I am not a veteran.
☐ Yes, I am a veteran, which means I served in active military, naval or air service, and was discharged or released under conditions other than dishonorable.

Please indicate below any programs or services with which you are involved at this time:

☐ Adult Education and Literacy Program
☐ Behavioral Health Administration (BHA)
☐ Center for Independent Living
☐ Child Protective Services
☐ Community Rehabilitation Program
☐ Department of Correction or Juvenile Justice
☐ Department of Labor, Licensing, & Regulation (DLLR)
☐ Department of Social Services (DSS)
☐ Developmental Disabilities Administration (DDA)
☐ Disability Organization or Advocacy Group
☐ Mental Hygiene Administration (MHA)
☐ Maryland Department of Disabilities (MDOD)
☐ Educational Institution (high school or post-secondary)
☐ Employer-funded services
☐ Federal Student Aid Program
☐ Medical Health Provider
☐ Mental Health Provider
☐ One-stop Employment/Training Center
☐ Other VR State Agency (Out-of-State)
☐ Public Housing Authority
☐ Social Security Administration (e.g. Disability Determination Services or local office)
☐ Veterans Benefits Administration
☐ Veterans Health Administration
☐ Workers Compensation
☐ Other Source: ______________________________
☐ Employment Network through Social Security Ticket-to-Work Program: ______________________________

Financial Information

How many dependents do you have, including yourself? __________
What is your gross monthly family income? $ ____________________

What is your primary source of support?

☐ Personal Income (employment earnings, interest, dividends, rent, retirement including Social Security retirement)
☐ Public Support (SSI, SSDI, Other Disability, TANF, VA, General Assistance, Worker’s Compensation, etc.)
☐ Spouse, Family and Friends
☐ Other Sources (private disability insurance and private charities)

Please identify your SSDI (Social Security Disability Insurance) Status:

☐ Allowed/Receiving Benefits ☐ Denied Benefits ☐ Application Pending ☐ Benefits Discontinued/Terminated
☐ Not an Applicant ☐ Status Not Known

Please identify your SSI (Supplemental Security Insurance) Status:

☐ Allowed/Receiving Benefits ☐ Denied Benefits ☐ Application Pending ☐ Benefits Discontinued/Terminated
☐ Not an Applicant ☐ Status Not Known

Please list all public benefit amounts (per month):

SSI Type: ☐ Aged ☐ Blind ☐ Disabled $ __________
SSDI: $ ____________
VA (Veterans’ Disability Benefits): $ ____________________
TANF (Dept. Social Services): $ ____________
General Assistance (Dept. Social Services): $ __________
Other Disability: $ ____________
Workers' Compensation: $ ___________
Unemployment Insurance (DLLR): $ __________
Other public benefit: $ ____

What medical insurance do you have? (check all that apply)

☐ None ☐ Medicaid/Medical Assistance ☐ Medicare ☐ Workers’ Compensation ☐ Affordable Care Act Exchange (State or Federal) ☐ Other Public Insurance – Source: ______________________________
☐ **I am employed and have private insurance through my own job.**
☐ **I am employed, and will have private insurance through the job I am doing now after a set period of time.**

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☐ **I have private insurance through other means (parent or other family member).**
If you have insurance, who is the policy holder? ______________________________
Medicaid Number: ____________________ **Medicare Number:** ____________________
Primary Adult Care (PAC) Number: ____________ **Worker's Compensation Claim Number:** ________

Education Information & History

If you are currently in high school:
What is your 10-digit Maryland State Student I.D.? ______________________
What grade are you in? _____ **What school do you attend?** ______________________
What year did you begin high school? _____ **What year will you graduate or exit school?** _____
When you graduate or exit school, do you expect to receive ☐ **a diploma or** ☐ **a certificate?**
Are you receiving education services and support under a 504 Accommodation Plan? ☐ Yes ☐ No
If not, are you receiving education services under an Individualized Education Plan (IEP)? ☐ Yes ☐ No
If you completed high school, did you exit with a diploma or a certificate? ☐ **Diploma** ☐ **Certificate** ☐ **Neither**
On what date did you complete high school? _____
If you are not currently in high school, what is the highest level of education you completed?

☐ No formal schooling
☐ Elementary or Secondary School Grade: _____
☐ High School Certificate of Completion
☐ High School Diploma
☐ GED
☐ Post-Secondary Education (no degree or certificate)
Number of credits earned toward degree: _____
☐ Vocational/Technical Certificate
☐ Vocational/Technical License
☐ AA Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Graduate Degree (e.g., PhD, EdD, JD, MD)

On what date did you complete your highest level of education? _____
Are you currently a student, an intern, in training or volunteering: ☐ Yes ☐ No
If applicable, describe current training/education: ______________________________
____

Employment Information

If you are not employed, when was the last date you were employed? ___________
If you are employed:
What is your job title? ______________________________
Is this self-employment or a Business Enterprise Program (BEP)? ☐ Self-Employment ☐ BEP ☐ No
How many hours do you work per week? ___________
What is your salary or average hourly wage (including tips)**? $**_____ ☐ Annually ☐ Monthly ☐ Weekly ☐ Hourly
Are you a transitioning service member? ☐ Yes ☐ No
Are you requesting services because you are in jeopardy of losing your job? ☐ Yes ☐ No
Have you received a termination notice or a Worker Adjustment & Retraining Notification (WARN) ☐ Yes ☐ No

Work History - *Please list your full work history, and start with most recent job first, or provide copy of your resume:*

Employer: ____________________ Start Date: __________ End Date: __________
Address: ______________________________
Job Title: ______________ Job Duties: ______________________________
____
Average Hours Worked Per Week: ___________ Salary: ___________
Reason for Leaving: ______________________________

Employer: ____________________ Start Date: __________ End Date: __________
Address: ______________________________
Job Title: ______________ Job Duties: ______________________________
____
Average Hours Worked Per Week: ___________ Salary: ___________
Reason for Leaving: ______________________________

Employer: ____________________ Start Date: __________ End Date: __________
Address: ______________________________
Job Title: ______________ Job Duties: ______________________________
____
Average Hours Worked Per Week: ___________ Salary: ___________
Reason for Leaving: ______________________________

Please attach any additional work history.

Disability Information – *Please list and describe your disabilities, beginning with your primary disability:*

1. **Disability:** ______________________ **Date of onset:** __________
   This disability is a result of: ______________________
   How does this disability limit your ability to obtain employment, work, or live independently?
   ____
   ____
2. **Disability:** ______________________ **Date of onset:** __________
   This disability is a result of: ______________________
   How does this disability limit your ability to obtain employment, work, or live independently?
   ____
   ____
3. **Disability:** ______________________ **Date of onset:** __________
   This disability is a result of: ______________________
   How does this disability limit your ability to obtain employment, work, or live independently?
   ____
   ____

Other Information

Please describe any special needs or work-related concerns you may have (e.g., personal care assistance, child care, transportation, criminal background): ______________________

____

What do you hope to gain from participating in rehabilitation services (i.e., the kind of work you want to do or your independent living goals)? ______________________

____

Other comments, concerns or additional information: ______________________

____

REQUEST FOR SERVICES AND NOTIFICATION OF RIGHTS

I am requesting rehabilitation services and have been given a copy of the Opening Doors to Employment, Informed Choice and Client Assistance Program brochures. I understand my rights and responsibilities under this program. Information that I have provided is to the best of my knowledge true, correct and complete. I understand that giving DORS untrue and/or fraudulent information may result in services not being provided or continued. By signing this request I give permission for DORS to verify my status as a recipient of Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI).

Before signing, please discuss with your DORS counselor any information you do not understand.

Applicant Signature/Date: ______________________

Signature of Parent or Representative: ______________________
(if applicant is in high school, under age 18 or has a legal guardian)

INFORMATION GATHERING

- The principal purposes served by gathering information requested on the Application, Financial Statement and individualized plan of services are 1) to determine your eligibility for rehabilitation services; 2) to determine what, if any financial participation you may be expected to provide; and 3) to plan your services.
- Refusal to provide the requested information will result in DORS finding you not eligible for services.
- You have a right to review, amend or correct the requested information under Maryland Annotated Code, State Government Article, Section 10-611-10-629.
- The requested information is not available for public inspection, unless you give written permission.
- The requested information is routinely shared with other governmental agencies when information is needed for you to obtain benefits or services; for audit, evaluation or research purposes connected with the administration of the rehabilitation program as long as confidentiality is safeguarded; and to obtain payment for services which have been provided when covered by third party resources.
- DORS requests the Social Security Number of applicants for services and uses it only for federal reporting purposes and, as applicable: (1) confirmation of Social Security benefits and presumption of eligibility, and (2) financial transactions.