NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
CHRIS EGAN, MSW, LCSW • Senior Director
KATHIE B. TROTTER, MS, CRC, LPC, CPM • Director

AGREEMENT OF UNDERSTANDING BETWEEN APPLICANT AND NC DIVISION OF VOCATIONAL REHABILITATION (VR) PROGRAM

Client Name:
SSN:
Date of Birth:

If you have an impairment or disability that keeps you from working and you need Vocational Rehabilitation (VR) services to engage in work, VR may be able to assist you. All services VR provides must directly relate to your goal of going to work. VR does not discriminate based on race, gender, age, color, national origin, religion, or disability.

INFORMED CHOICE

Informed choice is an ongoing process and partnership with your counselor, which provides you the opportunity to make choices and selections about your rehabilitation program. Your counselor will give you information or help you to get the information you need to make informed choices throughout your involvement with VR.

To determine your eligibility for services, it will be necessary to obtain information about your disability and how it affects employment. You may be asked to sign a consent form that allows your counselor to gather information about your disability that already exists about you. If your counselor feels additional information is necessary or if it is necessary to provide limited services to find out more about your disability for purposes of determining your eligibility for additional VR program services related to employment, you will be given the full opportunity to participate in the choice of those services and who provides those services. If you are unsure of how to get the information you need to make an informed choice, your counselor will help you.

YOUR RESPONSIBILITIES

You and your counselor _____ Phone: (919) 969-7350 are partners in the VR program. You will need to participate fully. That includes maintaining contact as needed to provide your counselor with the following information:

- Your impairment, disability, or problem(s) you are having, and where we can obtain information to help us determine your eligibility
- Any changes in your address, phone, health condition, job, or other areas that affect your rehabilitation program
- Any insurance or Workers' Compensation claims
- Your job goal and services you need to reach that job goal

COUNSELOR'S RESPONSBILITIES

- To gather the information needed to determine your eligibility within 60 days or less, or notify you why VR cannot determine your eligibility within this time frame;

- To explain and guide you through the application process;
- Your counselor will keep all records and information gathered about you confidential, in accordance with State and Federal law. However, records may be released without your consent in the following situations:
    - In order to protect you or others if you pose a threat to your safety or the safety of others;
    - If required by State or Federal law;
    - In response to an order issued by a judge, magistrate, or other authorized judicial officer;
    - In response to investigations in connection with law enforcement, child protective services, fraud, or abuse, unless expressly prohibited by State or Federal laws or regulations;
    - De-identified information, including earnings information, educational credential and skill attainment collected and reported on a quarterly basis to Federal and State workforce authorities as a requirement of participation and the program's compliance with funding requirements.

YOUR RIGHTS

- To receive services for determining eligibility without regard to your race, color, gender, religion, national origin, age, or disability;
- To have input in choices about service providers during the application process;
- To discuss with your counselor's supervisor decisions with which you do not agree or any concerns you cannot work out with your counselor. You may also request an Administrative Review of the decision, Mediation, and/or an Appeals Hearing by writing the Regional/Area Director describing clearly the decision you disagree with.

Regional / Area Director / Area Rehab. Supervisor: Alma P. Taylor

Address: 112 Dennis Dr., Sanford, NC 27330

Phone: (919) 775-4283

CLIENT ASSISTANCE PROGRAM (CAP)

If you cannot resolve your concern or problem by talking with VR staff, you may call the Client Assistance Program (CAP).

CAP Toll-Free, In-State 800-215-7227
Triangle Area (919) 855-3600
Email : NCCAP@dhhs.nc.gov
Website: https://www.ncdhhs.gov/client-assistance-program

ORDER OF SELECTION

The North Carolina Divisions of Vocational Rehabilitation Services and Services for the Blind VR programs have established an Order of Selection that will be implemented if resources are not sufficient to serve all individuals determined eligible. Categories for the Order of Selection will be based on the significance of the disability for each individual. You will be assigned a category at the time of the eligibility determination.

Categories being served at this time are: • All Categories
Categories not being served at this time are: • None

CODE OF CONDUCT

In order to maintain a safe and supportive environment for our staff and customers we ask that you comply with basic safety requirements. While we encourage active participation and communication, we do ask that this be done in a civil manner even when there are disagreements or uncomfortable discussions taking place. Should you have concerns about how staff is relating to you that you are unable to work out with staff, you are encouraged to talk with the manager of the office or with the Client Assistance Program 1-800-215-7227. You are always welcome to bring an advocate or family member with you should you desire.

We have listed below a list of behaviors that are not acceptable for anyone in contact with our staff either in the office or in the community. These same expectations apply for our staff as well. It should be noted that violation of this code of conduct may result in immediate termination of services from the VR program. In addition, law enforcement authorities may be contacted and appropriate legal action taken should a violation occur.

NO WEAPONS

NO THREATS (VERBAL OR PHYSICAL)

NO AGGRESSIVE BEHAVIOR (VERBAL OR PHYSICAL)

NO HARASSMENT

NO PROPERTY DAMAGE

By completing this application for VR services, I understand and agree to the following as indicated by initialing by specific items indicated immediately below as applicable and signing the application:

_____ The Divisions' order of selection has been explained to me and understand that an order of selection for services will be implemented if or when it is determined there are insufficient resources to serve all applicants who are determined eligible for services.

_____ My VR counselor may utilize databases if necessary to re-establish lost contact, verify employment information, earnings and benefits data, and educational credential attainment for mandatory state and Federal program-related reporting purposes.

_____ I grant staff permission to contact those personal contacts provided during the intake process for purposes of maintaining contact or for emergency purposes.

_____ I understand that if I choose to communicate with my VR counselor or program staff using unsecured email such as Gmail, Yahoo mail, etc., that such email correspondence with VR staff is subject to the North Carolina Public Records Law, and with the exception of information which is protected under privacy laws, may be disclosed to third parties and does become part of my case record.

_____ I will not engage program staff in social networking sites such as Twitter, Instagram, Facebook, or Linked In, etc., since using these methods would compromise my confidentiality.

By signing below I am indicating that I have read and understand this agreement, that I will abide by the Code of Conduct described above, that the information I have provided is complete and accurate and that I will be provided a copy of this document by my counselor.

_____ _____

Applicant Signature Date

_____ _____

DVRS Representative Signature Date

PARENT/GUARDIAN CONSENT

(for applicants under age 18 or with a legal guardian)

Please put a check mark beside the appropriate statement regarding how you would like to participate in the initial meeting.

☐ 1. I CONSENT FOR MY CHILD/WARD TO APPLY FOR VOCATIONAL REHABILITATION SERVICES AND PARTICIPATE IN AN INITIAL APPLICATION INTERVIEW WITHOUT ME BEING PRESENT.

☐ 2. I CONSENT FOR MY CHILD/WARD TO APPLY FOR VOCATIONAL REHABILITATION SERVICES AND PARTICIPATE IN AN INITIAL APPLICATION INTERVIEW WITH MY PRESENCE. I CAN BE REACHED AT _____ TO SCHEDULE AN APPOINTMENT.

☐ 3. I DO NOT CONSENT FOR MY CHILD/WARD TO APPLY FOR VOCATIONAL REHABILITATION SERVICES. [If you select this option, please stop here. This form does not require your signature.]

_____

Parent/Guardian Signature Date

NATIONAL VOTER RIGHTS ACT (NVRA) VOTER REGISTRATION PREFERENCE

IF YOU CHOOSE TO REGISTER OR PRE-REGISTER TO VOTE IN NORTH CAROLINA YOU MUST:

1. Be a citizen of the United States.
2. Be at least 18 years old by the date of the next general election.
3. Be a resident of the county in which you are registering and have lived at that actual address for at least 30 days prior to the date of the election.
4. Not be serving any part of a sentence for a felony conviction, including probation or parole. If previously convicted of a felony, citizenship and voting rights are automatically restored upon completion of the sentence. No special documentation is required.

All applications for registration must be received by your local County Board of Elections **no later than the 25 days** prior to any election for which you wish to vote.

Prospective voters between 16 and 17 years of age who meet the other qualifications listed above may **pre-register to vote**. To preregister, the person must indicate on the voter registration application that he or she is at least 16 years of age and that he or she understands

that they must be 18 years of age on or before election day to vote. The preregistered voter shall then be automatically registered upon his or her 18th birthday.

If you are not registered to vote where you live now, would you like to register to vote here today?

Please select/check one of the options below:

☐ YES, I would like to apply to register / pre-register to vote here today.

☐ YES, I would like to apply to register/preregister to vote, but I will take a voter registration application home to complete at a later time.

☐ NO, I am declining the opportunity to register/preregister to vote today.

☐ I am ALREADY REGISTERED to vote at my current address.

☐ I am ALREADY REGISTERED but I would like to update my voter registration information. I will complete a voter registration Application/Update form for this purpose.

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER/PREREGISTER TO VOTE AT THIS TIME. HOWEVER, YOU ARE STILL REQUIRED TO SIGN THIS FORM INDICATING THIS WAS PRESENTED TO YOU.

PLEASE READ, PRINT YOUR NAME AND DATE OF BIRTH, AND SIGN BELOW:

I have been offered the opportunity to register or preregister to vote at the agency named below and have been given a voter registration application. I understand that I will be offered the opportunity to register/preregister to vote at the initial application for service of assistance and with each recertification, renewal or change of address relating to such service or assistance.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If I choose to register/preregister to vote, the location where I completed the voter registration application form will be used only for voter registration purposes. I understand that applying to register or declining to register to vote will not affect the services that I will be provided by this agency. If I believe that someone has interfered with my right to register or to decline to register to vote, my right to privacy in deciding whether to register or in applying to register to vote, or my right to choose my own political party or other political preference, I may file a complaint with the North Carolina State Board of Elections, PO Box 27255, Raleigh, NC 27611-7255, or you may call the toll-free number, 1-866-522-4723.

Applicant Name _____ Date of Birth _____

NC Division of Vocational Rehabilitation Services

Applicant Signature _____ Date _____ Agency Name _____

VR Representative Signature _____

Referral Date: _____

DEMOGRAPHIC DATA

Name: _____
LAST First MIDDLE

Current Address: _____ Zip: _____

Telephone Number: _____ County: _____ Email: _____

Age: _____ Primary Disability Type: ☐ Physical Health ☐ Mental Health ☐ LD/ID ☐ Substance Abuse

Legal History: ☐ Yes ☐ No Probation/Parole: ☐ Yes ☐ No Pending Charges: ☐ Yes ☐ No

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SSN: _____ - _____ - _____ DOB: _____ / _____ / _____

Gender: ☐ Male ☐ Female

Race: ☐ White/Caucasian ☐ Black/ African American ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Other: _____

Hispanic Ethnicity: ☐ Cuban ☐ Puerto Rican ☐ Mexican American ☐ Other Hispanic/ Latino ☐ Unreported

Travel Information: ☐ Alone: ☐ Drives own vehicle ☐ Owns vehicle, Uses driver ☐ Transportation Arranged ☐ Public Transportation ☐ w/ Sighted Guide ☐ w/ Dog Guide ☐ w/ Cane ☐ w/ Wheelchair ☐ w/Assistive Devices ☐ During the Day ☐ During the Night ☐ Other: _____

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other: _____

REFERRAL SPECIFICS

Referral Source:
- ☐ Self-Referral
- ☑ Mental Health/ Medical Agency
- ☐ Social Services
- ☐ Social Security Administration
- ☐ IL/CIL
- ☐ Educational Institution
- ☐ State Dept. of Correction
- ☐ Worker's Comp
- ☐ Consumer/ Advocacy Groups
- ☐ Veterans Affairs
- ☐ Family/Friends
- ☐ Other: _____

Referral Contact:

Name: Caramone (LAST) Community (First) CRP (MIDDLE)

Current Address: _____ Zip: _____

Telephone Number: _____ County: _____ Email: _____

Relationship Type: _____ Legal Guardian?: ☐ Yes ☐ No

Reason for Referral:

What is your disability and how does it limit you?

_____

_____

_____

Do you want a job now? ☐ Yes ☐ No

You are interested in services to assist with:
- ☐ Preparing for and/or finding a job
- ☐ Maintaining a job
- ☐ Transitioning from school to work
- ☐ Performing independent living skills

What do you expect from the agency?

_____

_____

Are you currently receiving (and/or have applied to) services for treatment of disabling condition? ☐ Yes ☐ No

If so, where? _____

FOR OFFICE USE ONLY

Referral Date: _____ Counselor Name: _____

Caseload Assignment: _____ Counselor Code: _____

Applicant Last Name: _____

Office Use Only:

VR Case Type: ☐ Transition ☐ Vocational Rehabilitation ☐ Job Retention
☐ Supported Emp. ☐ Transitional/SE

Involvement with Other Agencies and Services:

_____

_____

What is your disability and how does it limit you? _____

_____

_____

Highest Level of Education Achieved: _____

Does client have IEP/504 plan? ☐ Yes ☐ No If yes, than which one?: ☐ IEP ☐ 504

Education History: (Secondary, College, University)

Start/End Date	Institution Type	Institution Name	Field of Study	Degree Sought	Degree Obtained
	☐ Public ☐ Private ☐ Home Schooled		High School General Education	☐ HS Diploma ☐ GED ☐ Special Ed	☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Certifications: _____

Are you in default on any student loans? ☐ Yes ☐ No

LEARNING PREFERENCE

(Check all that apply)

Audio/Visual Materials (Learn by watching): ☐ Yes ☐ No Written Materials: ☐ Yes ☐ No

Demonstration/Practice (Learn by doing) ☐ Yes ☐ No Other: _____

Are you proficient in reading? ☐ Yes ☐ No Are you proficient in math? ☐ Yes ☐ No

Applicant Last Name: _____

OTHER SKILLS BY SELF REPORT

Computer Skills (Check all that apply)

Word Processing: ☐ Yes ☐ No
Spreadsheets: ☐ Yes ☐ No
Presentation: ☐ Yes ☐ No
Electronic Mail: ☐ Yes ☐ No
Internet: ☐ Yes ☐ No

Typing

Touch Typist?: ☐ Yes ☐ No WPM: _____

Adaptive Technology (Check all that apply)

Braille Output ☐ Yes ☐ No
Dragon Naturally ☐ Yes ☐ No
JAWS ☐ Yes ☐ No
Window Eyes ☐ Yes ☐ No

Other Skills (please list)

_____
_____
_____
_____
_____
_____

Marital Status: _____ No. In Household _____ No. of Dependents: _____

Living Arrangements (pick one)

☐ Private Residence (independent, or with family or 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 _____

Employment at Application

Previously Employed? ☐Yes ☐ No
Number of Work Days: _____
Currently Working? ☐Yes ☐ No
Year Last Employed: _____
Days Missed Previous Year: _____
Sick Leave Type (if applicable) ☐ Paid ☐ Unpaid

Conflicts with Co-workers and supervisors in past employment? ☐ Yes ☐ No If yes, please explain:

_____
_____

WORK HISTORY

(Current or most recent first)

Occupation: _____ Job Title: _____
Start Date: ___/___ End Date: ___/___ Employer: _____
Street: _____ City: _____ State: _____ ZIP: _____
Phone Number: (___) ___-_____ Contact Name: _____
Pay Period: _____ Amount: $_____ Hours per Week _____ Days per Week _____

Duties & Skills: _____
_____

Accommodations Received: _____
_____

Reason For Leaving: _____
_____

Applicant Last Name: _____

ADDITIONAL WORK HISTORY

Occupation: _____ Job Title: _____

Start Date: ___/___ End Date: ___/___ Employer: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone Number: (___) ___-_____ Contact Name: _____

Pay Period: _____ Amount: $_____ Hours per Week _____ Days per Week _____

Duties & Skills: _____

_____

Accommodations Received: _____

_____

Reason For Leaving: _____

_____

Occupation: _____ Job Title: _____

Start Date: ___/___ End Date: ___/___ Employer: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone Number: (___) ___-_____ Contact Name: _____

Pay Period: _____ Amount: $_____ Hours per Week _____ Days per Week _____

Duties & Skills: _____

_____

Accommodations Received: _____

_____

Reason For Leaving: _____

_____

Medical Benefits:

Do you have...

Medicaid	☐ Yes	☐ No
Medicare	☐ Yes	☐ No
Other Public Insurance	☐ Yes	☐ No
Employment-based Ins	☐ Yes	☐ No
Other Private Insurance	☐ Yes	☐ No
Not Yet Eligible for Private Ins	☐ Yes	☐ No
Veterans Benefits	☐ Yes	☐ No

Applicant Last Name: _____

Other Income Source at Application:

Do you receive...

SSI – Aged	$ _____	General Assistance	$ _____
SSI – Blind	$ _____	Veteran Disability Benefits	$ _____
SSI – Disabled	$ _____	All other Disability Benefits	$ _____
SSDI	$ _____	Unemployment Compensation	$ _____
Workers' Compensation	$ _____	Retirement	$ _____
Work First	$ _____	Social Security Retirement	$ _____
	_____	Annuity or other non-disabled insurance	$ _____
Food Stamps	$		
Survivor Benefits	$ _____	Other	$ _____

Primary Source of Support at Application:

- ☐ Personal Income (employment earnings, interest, dividends, rent, retirement)
- ☐ Family and Friends
- ☐ All other sources (e.g. private disability insurance and private charities)

Medical/Mental Health Treatment Provider:

Clinic/Hospital: _____ Name: _____

_____ _____ _____ _____
Street City State ZIP

_____ _____ _____
Phone Fax Specialty

Reason For Tx: _____

Beginning: __/__/____ Ending: __/__/____

Clinic/Hospital: _____ Name: _____

_____ _____ _____ _____
Street City State ZIP

_____ _____ _____
Phone Fax Specialty

Reason For Tx: _____

Beginning: __/__/____ Ending: __/__/____

Medical/Mental Health Treatment Provider (continued...)

Clinic/Hospital: _____ Name: _____

_____ _____ _____ _____
Street City State ZIP

_____ _____ _____
Phone Fax Specialty

Reason For Tx: _____

Beginning: __/__/____ Ending: __/__/____

Applicant Last Name: _____

Special Categories

Projects w/ Industry: ☐ Yes ☐ No IEP (Current or Previous)?: ☐ Yes ☐ No
Service Connected Disability: ☐ Yes ☐ No Eligible to work in the USA: ☐ Yes ☐ No
Social Security Card: ☐ Yes ☐ No Birth Certificate: ☐ Yes ☐ No Picture ID: ☐ Yes ☐ No
Valid Driver's License: ☐ Yes ☐ No License Type: _____ NCDL#: _____

Special License or Restrictions: ☐ Yes ☐ No If "Yes" explain: _____

Can you pass a drug screen: ☐ Yes ☐ No Can you pass a background check: ☐ Yes ☐ No
Have you ever been arrested: ☐ Yes ☐ No Do you have pending charges: ☐ Yes ☐ No

Explain pending charges: _____

Previous Criminal History: ☐ Yes ☐ No Explain criminal history: _____

Felony convictions: ☐ Yes ☐ No Explain felony convictions: _____

Are you currently on parole: ☐ Yes ☐ No Probation: ☐ Yes ☐ No

Probation/Parole Officer Name: _____ Phone: _____

Address: _____

Language Preference: ☐ English ☐ Spanish ☐ ASL ☐ Signed English ☐ Other: _____

Military Service

Military Service: ☐ Yes ☐ No If yes, what branch? _____

Rank: _____ Discharge Date: _____ Type of Discharge: _____

Office Use Only:
Subrogation Case: ☐ Yes ☐ No Ticket to Work: ☐ Yes ☐ No