Lehigh – Northampton LINK Cross-training session 1-11-12

Presenter: Liana Reynolds, Vocational Rehabilitation Supervisor
PA Dept. of Labor and Industry
Office of Vocational Rehabilitation
45 N 4th St., Allentown, PA 18102
610-821-6441 or 800-922-9536
Ext. 3105; or lreynolds@pa.gov

The Office of Vocational Rehabilitation (OVR) serves people whose disabilities present a substantial impediment to employment. Services are provided to individuals who can benefit from and who need assistance to prepare for, enter, engage in, or retain employment.

Persons applying for OVR services to get or hold a job are assigned to a vocational rehabilitation counselor who, after meeting with the individual, will review available documents and determine eligibility. If the person is eligible for OVR services, the customer and the counselor will develop an Individualized Plan for Employment (IPE) to include a specific job goal, the services required to achieve the goal, criteria for evaluating progress, and responsibilities. Services provided are those that the individual requires in order to achieve the agreed-upon job goal and may include one or more of the following:

Vocational guidance and counseling – provided to all eligible customers by the OVR counselor without regard to income

Evaluative services to better understand the impairment, the impediment to employment, or the individual's aptitudes and abilities

Restoration services – as prescribed. Medical insurance must be used when available.

Training services to gain the skill necessary to achieve the goal. Education grants must be used when available.

See brochure for additional information. Many services are provided through community partners.

Individuals who are ready for employment services may call our office to request an application, which can be mailed to them. Applications can also be obtained at local CareerLinks. OVR is also initiating an on-line application process through the Comprehensive Workforce Development System (cwds.state.pa.us).

OFFICE OF VOCATIONAL REHABILITATION
Allentown District Office
45 North 4th Street
Allentown, PA 18102-3467
Telephone: (610) 821-6441 - (610) 821-6144/TT - 1-800-922-9536

INSTRUCTIONS TO REFERRING AGENCIES/FACILITIES:

1. Have the individual you are referring complete the OVR "Pre-Application Packet"

2. Return the completed "Pre-Application Packet" to OVR *with medical records or other information which will confirm that individual's disability(ies).*

Should you have any questions regarding this process, please call our office.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

OFFICE OF VOCATIONAL REHABILITATION

Dear Applicant,

This is your Employment Planning Application for the Office of Vocational Rehabilitation. Please read carefully.

We have received your referral. Please complete all sections of the application to the best of your ability or contact our office if you need assistance. Return the attached application in the envelope provided (NO POSTAGE IS NEEDED).

After we receive your completed application, a Vocational Rehabilitation Counselor will contact you.

WHAT YOU SHOULD KNOW BEFORE YOU APPLY:

The Pennsylvania Office of Vocational Rehabilitation (OVR) is a state agency. Its mission statement is:

To assist Pennsylvanians with disabilities to secure and maintain employment and independence.

You should apply if:

1. You have a disability
2. Your disability causes you substantial problems in preparing for, getting, or maintaining employment, and
3. You want to work

The core services provided by OVR are vocational counseling and guidance and job placement assistance. Other services and options will be described by your Vocational Rehabilitation Counselor and will be provided only if required to achieve an employment outcome.

During your first meeting with a Vocational Rehabilitation Counselor you will receive an OVR Handbook and Client Assistance Program brochure.

There is no charge for counseling and placement services. Based upon a Financial Needs Test, you may have to contribute to the cost of other services.

Sincerely,

Office of Vocational Rehabilitation

Rev. ADO 1/4/08

OVR

OFFICE OF VOCATIONAL REHABILITATION

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY

EMPLOYMENT PLANNING APPLICATION

Personal Data

Name: First _____ **Middle Initial**_____ **Last**_____

Maiden name or other under which records may be listed _____

Social Security Number _____ **Date of Birth** _____ **Age**_____

CWDS Participant ID number (if known) _____

Citizenship Status: (please circle) U.S. Citizen Non U.S. Citizen

Permanent Alien Temporary Alien Refugee Illegal Alien Unknown

Are you legal to work in the U.S.: (Please circle) YES NO

Ethnicity: Hispanic/Latino (Please circle) YES NO

Race: (Please circle) American Indian/Alaskan Native Asian Black/African American Hawaiian Native/Other Pacific Islander White Do not wish to disclose

Gender: (please circle) Male Female

Highest Level of Education Completed: _____

Are you a Veteran: (please circle) YES NO **Are you the spouse of a Veteran:** YES NO

Home (Location) Address:

Address _____ Apt _____

City _____ State_____ Zip Code _____

County _____

Mailing Address: Same as above ☐

Address _____ Apt_____

City _____ State_____ Zip Code _____

County _____

Other Personal Information

Contact Information:

Home Phone _____ Cell Phone _____ Work Phone _____

Fax Number_____ Email _____

Preferred Contact Method: (please circle one)

Home Address Mailing Address Home Phone Cell Phone Fax Number Email

Language Preference: (please circle) English Spanish Other _____

Do you need an interpreter: Yes____ No_____ If yes, specify: _____

Who referred you to OVR: _____

Why were you referred to OVR: _____

Voter Registration (to be completed by OVR counselor):
- ☐ Application Mailed/Delivered – Client
- ☐ Application Mailed/Delivered – Agency
- ☐ Declined to apply – already registered
- ☐ Declined to apply for registration

Emergency Contact:

Name _____ Relationship _____

Phone _____

Detailed Profile

Work Record List

Current Employment Status (please circle): Working Not Working
If currently working: Weekly Earnings: _____ Hours worked per week _____

Employer Name: _____ **Job Title:** _____

Date: From _____ to _____ Salary: _____ Part time/ Full time (circle one)

Duties: _____

How does your disability keep you from returning to this job:

_____

Reason for Leaving:

_____

Employer Name: _____ **Job Title:** _____

Date: From _____ to _____ Salary: _____ Part time/ Full time (circle one)

Duties : _____

How does your disability keep you from returning to this job:

_____

Reason for Leaving:

_____

Employer Name: _____ **Job Title:** _____

Date: From _____ to _____ Salary: _____ Part time/ Full time (circle one)

Duties: _____

How does your disability keep you from returning to this job:

_____

Reason for Leaving:

_____

(to be completed by OVR counselor):

☐ Employment without supports ☐ Extended Employment ☐ Self-employed ☐ Homemaker
☐ Unpaid family worker ☐ Employment with supports ☐ Not employed, HS student
☐ Not employed, all other students ☐ Not employed, intern trainee ☐ Not employed, other

HIGH SCHOOL

School Name _____ STATE ___ Last grade completed ____ Date _____

If you did not complete high school, have you earned a GED: YES ____ NO _____

Why did you leave school: _____

Were you in a learning support/emotional support program or special education program? YES ____ NO ____

Please list below other training (e.g. vo-tech, college, trade, technical, business, etc.)

Name & Address of School	Course	From –> To Date	Type of Training Degree/Certificate	Reason for Leaving

Military Record List

Branch of Service: _____ Type of Discharge: _____

Date of Entry: _____ Separation Date: _____

Household Composition

Family Size (number of dependents in your family including yourself): _____

People Living in the Household:

First and Last Name	Age	Relationship	Employer

Living Arrangements (to be completed by OVR counselor):

☐ Private residence ☐ Community Residential/Group Home ☐ Rehabilitation Facility ☐ Mental Health Facility
☐ Nursing Home ☐ Adult Correctional Facility ☐ Halfway House ☐ Homeless
☐ Other ☐ Substance Abuse Treatment

Financial (to be completed by OVR counselor):
Primary Income Source:
☐ Personal Income (Wages, Tips, Interest, Dividends, Rent, etc.)
☐ Family and Friends (Someone else's earnings, Unemployment check, etc.)
☐ Public Support (SSI, SSDI, Public Welfare, Workers Comp, Veteran Disability, etc.)
☐ All Other Sources (Private Disability Insurance, Private Charities, etc.)
☐ Other Income Source: _____
Amount: _____

Agency Involvement (List any facilities, rehab programs or social/community agencies where you are or were receiving services)

Name of Agency	Service Received	Counselor/Case Manager	Phone Number

Disability Information
What is your disability: _____ **Date** of Onset: _____

How does your disability interfere with working or maintaining your independence: _____

Does your doctor/therapist/psychiatrist support your desire to return to work: _____ YES _____ NO

What do you think OVR can do to help you get or keep a job or maintain your independence: _____

What jobs or careers interest you: _____

Impairment/Cause Code Combination **(to be completed by OVR counselor)**

Disability	Impairment Code	Cause Code	Onset	Comments

Severity Status:
☐ Most Significantly Disabled (MSD)
☐ Significantly Disabled (SD)
☐ Not Significantly Disabled (NSD)
☐ Undetermined (U)

MEDICAL INFORMATION

We need information about your physical and mental health status to help determine your eligibility & how your disability interferes with your ability to work/live independently. Answers to these questions help us obtain the documents that prove you have a disability. **Please bring any medical information or records you have to your initial interview.**

Doctor Name & Address	Doctor Type	Date of last Appt	Date of next Appt.	Reason for visit

Medications

Are you taking any medications? _____**YES** (If yes, please list below) _____**NO**

Medication Name	Type	Dosage	Reason	Side Effects

Medical Insurance

Type of Insurance	Insurance ID Number	Specify Carrier
Medicaid		
MA for workers with disabilities (MAWD)		
Medicare		
Private Insurance/Employment		
Private Insurance/other		
Worker Compensation		

Are you receiving disability payments from any other source: ____YES ____NO

If yes:

Name of Company paying these benefits: _____

Monthly amount received: $_____

Are you involved in any lawsuits related to your disability: ____YES ____NO

If yes, please explain:_____

_____

_____

Attorney information:

Name _____ Phone _____

Address _____

_____

ɔ any of the following interfere with your ability to work/live independently? (Check all that apply)

ɛnsory:

Cooking safely and efficiently
Dialing Telephone Numbers
Fainting
Hallucinations/Delusions
Hearing
Housekeeping
Identifying Money
Identifying Colors & Condition of Clothing
Laundry

☐ Moving Safely in Various Environments: home, community, shopping
☐ Reading: Newspapers, Magazines, Books, Bills, Letters, Prices, Phone Numbers, Labels
☐ Seeing a Clock or Watch
☐ Seeing Faces & Recognizing People
☐ Seeing Large Objects
☐ Speaking
☐ Using Appliances with Numbers & Dials
☐ Watching Television
☐ Writing: Signature, Writing Checks, Notes, Grocery Lists, etc.)

ıysical Tolerance:

Balancing
Chest Pain
Chronic Cough
Climbing Stairs
Digestion
Energy/Stamina
Gynecological Problems
Kneeling
Lifting/Bending
Numbness

☐ Reading Typewritten Material
☐ Shortness of Breath
☐ Sitting
☐ Skin Problems
☐ Sleep
☐ Standing/Walking/Running
☐ Swelling of Hands & Legs
☐ Weakness/Pain in Hands/Arms
☐ Weakness/Pain in Legs/Feet

ɔgnitive/Emotional:

Concentrating
Depression
Enjoying Hobbies
Ever Been Unconscious

☐ Getting Along with People
☐ Health maintenance
☐ Learning
☐ Nervousness (Anxiety/Panic)
☐ Reading/Writing/Math
☐ Remembering
☐ Stress Tolerance

ave you ever had, or been told you have:

Alcohol Problem
Asthma, Lung Disease/Respiratory
Blood Disease
Cancer
Developmental Disability
Diabetes
Drug Problem
Eating Disorder
Gastrointestinal Problems
Heart Trouble/Cardiac & Circulatory

☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney or Urinary Problem or End State Renal Disease & Genitourany System Disorders
☐ Mental Impairments
☐ Musculoskeletal: Arthritis, Rheumatism, Amputations, Fractures/ Injuries–resulted in permanent loss/impairment of Limb Function
☐ Neurological Impairment/Disorders due to Stroke/Seizures/ Parkinson's
☐ Other **
☐ Psychiatric or Emotional Disorder
☐ Tuberculosis

Other _____

ɔ you use a cane, brace, wheelchair, hearing aid, low vision aid or other assistive device? ___YES ____NO
YES, explain:_____

ɜn you travel independently: ____YES ____NO If NO, explain:_____

sual Acuity if it affects your ability to work
Ɔ (right eye)____ OS (left eye)_____ Visual Fields ___Normal ___Restricted ___20 degrees or less

Legal Issues

Have you ever been convicted of a felony (please circle): YES NO

Have you ever been convicted of a misdemeanor (please circle): YES NO

If yes, what is your legal status now (please circle):

Probation Pending Work Release Community Corrections

Parole Other: _____

Name of probation or parole officer: _____

Phone # of probation or parole officer: _____

Drug and Alcohol Issues

Do you now or have you ever used alcohol or other drugs to the extent that it caused legal, personal, or employment problems (please circle): YES NO

If YES, please describe: _____

_____

How long have you used alcohol or other drugs: _____

What is your drug of choice: _____

When did you last use alcohol or other drugs: _____

What are you currently doing to maintain sobriety: _____

_____

_____

Transportation

Do you have a car (please circle): YES NO

Do you have a driver's license (please circle): YES NO

Have you ever been convicted of D.U.I. (please circle): YES NO

Is public transportation available (please circle): YES NO

If yes, is it accessible (please circle): YES NO

Do you have other transportation available (please circle): YES NO

Additional space (if needed)