Overland Park Service Center
8915 Lenexa Drive
Overland Park, KS 66214

Kansas
Department for Children
and Families

Phone: (913) 826-7300
Fax: (913) 826-7583
www.dcf.ks.gov

Laura Howard, Secretary

Laura Kelly, Governor

Dear Applicant,

Thank you for your interest in Kansas Rehabilitation Services (Vocational Rehabilitation Services).

Enclosed is a Service Application which you should complete to the best of your ability and return as soon as possible to 8915 Lenexa Drive, Overland Park KS 66214. The date the completed and signed application is received may affect the availability of funding for needed services. If you are under 18 or have a legal guardian, please ask that person to also sign all paperwork.

Also enclosed is a Handbook of Services that explains our guidelines and services. You may find this handbook, the enclosed Service Application and other helpful information on our website at www.dcf.ks.gov by clicking on the link Employment Services under the heading Rehabilitation Services.

A counselor will be calling or mailing a letter to you to schedule an initial meeting when your application is received. If possible, bring with you to your first meeting any available information about your disability, such as diagnosis, limitations, restrictions and a list of your doctors with addresses. We look forward to hearing from you.

Please send all application information to:

DCF Overland Park Service Center
Attn: Vocational Rehabilitation
8915 Lenexa Drive
Overland Park KS 66214

Sincerely,

Kansas Rehabilitation Services
General RS Number: 913-942-3303

Encl: Handbook of Services
Service Application
Client Questionnaire
Health Assessment
Release of Information for requesting records
Release of Information for communication
IRS W9
Map to DCF – Overland Park Service Center

Kansas
Department for Children and Families
Rehabilitation Services

Application for Vocational Rehabilitation Services

Is Vocational Rehabilitation the right program for you?

Some brief information about the Vocational Rehabilitation (VR) program might help you decide whether to apply for services.

- VR serves people with any type of permanent physical, intellectual or mental disability.
- VR is an employment program. The purpose of VR is to help Kansans with disabilities become employed. We may also be able to provide services to help you keep the job you already have if your disability is causing difficulties for you at work.
- You must apply for services and be found eligible in order to receive services. After you apply, our staff will determine if you have a disability that is a significant impediment to employment, and if you require VR services to become employed. You may be asked to provide additional information about your disability, medical services and employment history to help determine if you are eligible.
- If you are eligible for services, a counselor will work with you to develop an Individual Plan for Employment (IPE). The IPE will list your employment goal and the services you will receive. The counselor will help you look at your employment options so you can make informed choices about the type of work you want to seek.
- Services are individualized according to each eligible person's unique rehabilitation needs, disability and employment goal.
- You may be asked to help pay for some services if it is determined that you or your family have the financial resources to do so.

If you have a disability and you want to work, start your road to employment today by completing this application for VR services. If you need help to answer any of these questions, please ask VR staff for assistance.

Information about you

LAST NAME | FIRST NAME | MIDDLE INITIAL | SOCIAL SECURITY NUMBER

PREVIOUS LAST NAMES USED, SUCH AS MAIDEN NAME OR MARRIED NAMES

CURRENT STREET ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE

DATE OF BIRTH | PHONE NUMBER | CELL PHONE NUMBER | COUNTY OF RESIDENCE

EMAIL ADDRESS | CONTACT PERSON'S NAME AND PHONE NUMBER (someone who would be able to give you a message)

GENDER

- ☐ MALE
- ☐ FEMALE
- ☐ NONBINARY OR ANOTHER GENDER
- ☐ PREFER NOT TO ANSWER

MARITAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ SEPARATED
- ☐ DIVORCED
- ☐ WIDOWED

RACE

- _____ WHITE
- _____ BLACK OR AFRICAN AMERICAN
- _____ AMERICAN INDIAN OR ALASKA NATIVE
- _____ ASIAN
- _____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

U.S. CITIZEN

☐ YES ☐ NO

IF NO, DO YOU HAVE AN ALIEN REGISTRATION CARD?

☐ YES ☐ NO

IF NO, DO YOU HAVE AN EMPLOYMENT AUTHORIZATION DOCUMENT?

☐ YES ☐ NO

YOU MUST HAVE A VISA WHICH ALLOWS EMPLOYMENT IN THE COMPETITIVE MARKETPLACE TO BE ELIGIBLE FOR SERVICES.

HISPANIC

- ☐ YES
- ☐ NO

U.S. MILITARY VETERAN

- ☐ YES
- ☐ NO

PRIMARY DISABILITY

What is the primary medical condition, injury, physical/mental impairment or disability that limits your ability to work? List or describe.

When did this disability begin (year)? _____

SECONDARY DISABILITY

Please list any other conditions, impairments or disabilities that limit your ability to work.

When did these conditions/disabilities begin (year)? _____

HIGHEST LEVEL OF EDUCATION (CHECK ONE)

- ☐ NO FORMAL SCHOOLING
- ☐ ELEMENTARY (GRADES 1-8)
- ☐ SOME HIGH SCHOOL BUT NO DIPLOMA (GRADES 9-12)
- ☐ SPECIAL EDUCATION CERTIFICATE/DIPLOMA OR CERTIFICATE OF ATTENDANCE
- ☐ HIGH SCHOOL GRADUATE OR GED
- ☐ SOME UNIVERSITY, COLLEGE OR TECH COLLEGE BUT NO DEGREE OR CERTIFICATE
- ☐ ASSOCIATE DEGREE
- ☐ BACHELOR'S DEGREE
- ☐ MASTER'S DEGREE
- ☐ DEGREE ABOVE MASTER'S, SUCH AS PH.D., ED.D., J.D.
- ☐ VOCATIONAL/TECHNICAL CERTIFICATE
- ☐ OCCUPATIONAL CREDENTIAL BEYOND UNDERGRADUATE
- ☐ OCCUPATIONAL CREDENTIAL BEYOND GRADUATE

CURRENT LIVING ARRANGEMENT (CHECK ONE)

- ☐ PRIVATE RESIDENCE (ON YOUR OWN, WITH YOUR FAMILY OR WITH A ROOMMATE)
- ☐ GROUP HOME
- ☐ REHABILITATION FACILITY
- ☐ MENTAL HEALTH FACILITY
- ☐ NURSING HOME
- ☐ JAIL OR CORRECTIONAL FACILITY
- ☐ HALFWAY HOUSE
- ☐ SUBSTANCE ABUSE TREATMENT CENTER
- ☐ HOMELESS/SHELTER
- ☐ OTHER

ARE YOU A STUDENT IN HIGH SCHOOL AT THE TIME OF THIS APPLICATION?

- ☐ NO, I'M NOT A HIGH SCHOOL STUDENT AT THIS TIME.
- ☐ YES, I'M IN HIGH SCHOOL AND I HAVE A 504 ACCOMMODATION PLAN.
- ☐ YES, I'M IN HIGH SCHOOL AND I'M RECEIVING SERVICES THROUGH AN INDIVIDUAL EDUCATION PLAN (IEP).
- ☐ YES, I'M CURRENTLY A HIGH SCHOOL STUDENT, BUT I DO NOT HAVE EITHER A 504 PLAN OR AN IEP.

WHO REFERRED YOU TO VR? (CHECK ONE)

- ☐ GRADE SCHOOL OR HIGH SCHOOL
- ☐ UNIVERSITY, COLLEGE OR TECHNICAL COLLEGE
- ☐ DOCTOR OR HOSPITAL (PUBLIC OR PRIVATE)
- ☐ MEDICAID (KANCARE, HEALTHWAVE, WORKING HEALTHY, WORK, MANAGED CARE ORGANIZATIONS)
- ☐ ECONOMIC AND EMPLOYMENT SERVICES
- ☐ CHILD SUPPORT SERVICES
- ☐ A REHABILITATION PROGRAM IN YOUR COMMUNITY
- ☐ SOCIAL SECURITY ADMINISTRATION OR DISABILITY DETERMINATION SERVICES
- ☐ ONE-STOP EMPLOYMENT/TRAINING CENTER (KANSASWORKS)
- ☐ SELF REFERRAL
- ☐ OTHER SOURCES
- ☐ AMERICAN INDIAN VR SERVICES PROGRAM
- ☐ CENTER FOR INDEPENDENT LIVING
- ☐ CHILD PROTECTIVE SERVICES
- ☐ CONSUMER ORGANIZATIONS ADVOCACY GROUP
- ☐ EMPLOYER
- ☐ FAITH BASED ORGANIZATION
- ☐ FAMILY OR FRIENDS
- ☐ INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SERVICE PROVIDER
- ☐ MENTAL HEALTH PROVIDER (PUBLIC OR PRIVATE)
- ☐ PUBLIC HOUSING AUTHORITY
- ☐ STATE DEPARTMENT OF CORRECTIONS/JUVENILE JUSTICE
- ☐ STATE EMPLOYMENT SERVICE AGENCY
- ☐ VETERAN'S ADMINISTRATION
- ☐ WORKER'S COMPENSATION
- ☐ OTHER STATE AGENCIES
- ☐ VR AGENCIES IN OTHER STATES
- ☐ ADULT EDUCATION

ACCOMMODATIONS FOR COMMUNICATIONS (CHECK ONE)

- ☐ REGULAR PRINT
- ☐ BRAILLE
- ☐ LARGE PRINT
- ☐ TAPE
- ☐ CD ☐ 3,5 DISK
- ☐ OTHER LANGUAGE (SPECIFY)_____

FOR OFFICE USE ONLY

Information about employment

ARE YOU WORKING?___☐ YES ___☐ NO

If yes, where:_______________ Job title:_______________ Hours per week: _______________

If yes, current weekly earnings:_______________(gross wages, salaries, tips or commissions before payroll or tax deductions)

FOR OFFICE USE ONLY – EMPLOYMENT AT APPLICATION

_____ Employment without Supports in Integrated Setting
_____ Extended Employment
_____ Self-employment (except BEP)
_____ State Agency-managed Business Enterprise Program (BEP)
_____ Homemaker
_____ Unpaid Family Worker
_____ Employment with Supports in Integrated Setting
_____ Not employed: Student in Secondary Education
_____ Not employed: All other Students
Not employed: Trainee, Intern or Volunteer
_____ Not employed: Other

IF YOU HAVE WORKED BEFORE, PLEASE LIST THE FOLLOWING INFORMATION FOR YOUR MOST RECENT JOBS:

NAME OF BUSINESS: _______________

JOB YOU HAD: _______________

TIME PERIOD WHEN YOU WORKED THERE: _______________

REASON FOR LEAVING: _______________

NAME OF BUSINESS: _______________

JOB YOU HAD: _______________

TIME PERIOD WHEN YOU WORKED THERE: _______________

REASON FOR LEAVING: _______________

NAME OF BUSINESS: _______________

JOB YOU HAD: _______________

TIME PERIOD WHEN YOU WORKED THERE: _______________

REASON FOR LEAVING: _______________

WHAT ARE THE STRENGTHS OR SKILLS YOU HAVE THAT ARE HELPFUL IN THE WORKPLACE?

Information about resources

ARE YOU CURRENTLY RECEIVING ANY OF THE FOLLOWING?

IF YES, PLEASE CHECK THEN LIST THE MONTHLY AMOUNT.			**FOR OFFICE USE ONLY**
_____SSDI (SOCIAL SECURITY DISABILITY INSURANCE)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____SSI (SUPPLEMENTAL SECURITY INCOME)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____GENERAL ASSISTANCE (PUBLIC ASSISTANCE)	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____VETERANS' DISABILITY BENEFITS	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____WORKERS COMPENSATION	AMOUNT:	$ _____	VERIFIED? Y/N_____
_____ANY OTHER PUBLIC SUPPORT	AMOUNT:	$ _____	VERIFIED? Y/N_____

WHAT IS YOUR PRIMARY (LARGEST) SOURCE OF SUPPORT? CHECK ONE.

☐ EMPLOYMENT EARNINGS
☐ PERSONAL INCOME (INTEREST, DIVIDENDS, RENT, RETIREMENT INCLUDING SOCIAL SECURITY RETIREMENT)
☐ FAMILY AND FRIENDS (INCLUDES EARNINGS OF A SPOUSE)
☐ GENERAL ASSISTANCE (PUBLIC ASSISTANCE)
☐ VETERANS' DISABILITY BENEFITS
☐ PUBLIC SUPPORT (SSI, SSDI, TANF)
☐ ALL OTHER SOURCES (INCLUDE PRIVATE DISABILITY INSURANCE AND PRIVATE CHARITIES)

TO HELP US COORDINATE YOUR SERVICES, PLEASE CHECK OTHER SERVICES YOU ARE RECEIVING.

YOU MAY CHECK UP TO THREE.

_____ AMERICAN INDIAN VR SERVICES PROGRAM
_____ CENTER FOR INDEPENDENT LIVING
_____ CHILD PROTECTIVE SERVICES
_____ A REHABILITATION PROGRAM IN YOUR COMMUNITY
_____ CONSUMER ORGANIZATION OR ADVOCACY GROUP
_____ GRADE SCHOOL OR HIGH SCHOOL
_____ UNIVERSITY, COLLEGE OR TECHNICAL SCHOOL
_____ EMPLOYER
_____ TICKET TO WORK EMPLOYMENT NETWORK
_____ FEDERAL STUDENT AID (PELL, SEOG, WORK STUDY)
_____ INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AGENCY
_____ DOCTOR OR HOSPITAL (PUBLIC OR PRIVATE)
_____ MENTAL HEALTH PROVIDER (PUBLIC OR PRIVATE)
_____ ONE-STOP EMPLOYMENT/TRAINING CENTER (KANSASWORKS)
_____ PUBLIC HOUSING AUTHORITY
_____ SOCIAL SECURITY ADMINISTRATION OR DISABILITY DETERMINATION SERVICES
_____ STATE DEPARTMENT OF CORRECTIONS/JUVENILE JUSTICE
_____ STATE EMPLOYMENT SERVICE AGENCY
_____ ECONOMIC AND EMPLOYMENT SERVICES
_____ VETERAN'S ADMINISTRATION
_____ WORKERS COMPENSATION
_____ OTHER STATE AGENCIES
_____ VR AGENCIES IN OTHER STATES
_____ OTHER
_____ NONE

DO YOU HAVE ANY OF THE FOLLOWING TYPES OF MEDICAL INSURANCE COVERAGE?

_____ MEDICAID (KANCARE)
_____ MEDICARE
_____ PUBLIC INSURANCE FROM OTHER SOURCES (WORKERS COMPENSATION OR HEALTHWAVE)
_____ PRIVATE INSURANCE THROUGH YOUR OWN EMPLOYER
_____ NOT YET ELIGIBLE FOR PRIVATE INSURANCE THROUGH EMPLOYER, BUT WILL BE AFTER A CERTAIN PERIOD OF EMPLOYMENT
_____ PRIVATE INSURANCE THROUGH OTHER MEANS (SUCH AS THROUGH PARENTS OR FAMILY)

Information about your expenses

HOW MANY PEOPLE CURRENTLY LIVE AT YOUR HOUSE?_____(INCLUDE RELATIVES AND OTHERS)

WHAT ARE THE CURRENT MONTHLY EXPENSES FOR YOUR HOUSEHOLD? PLEASE LIST BELOW

HOUSING	AMOUNT:	$ _____	WATER	AMOUNT:	$ _____
NATURAL GAS	AMOUNT:	$ _____	CABLE	AMOUNT:	$ _____
ELECTRICITY	AMOUNT:	$ _____	INTERNET	AMOUNT:	$ _____
PROPANE	AMOUNT:	$ _____	TELEPHONE	AMOUNT:	$ _____
TRASH	AMOUNT:	$ _____	CELL PHONE	AMOUNT:	$ _____

IF YOU ARE FOUND ELIGIBLE, YOU MAY BE ASKED TO PROVIDE DOCUMENTATION OF THESE EXPENSES, DEPENDING ON SERVICES THAT WOULD BE INCLUDED IN YOUR IPE.

Acknowledgements

In making this application for vocational rehabilitation services, I acknowledge that:

- I am applying for vocational rehabilitation services for the specific purpose of getting and/or keeping a job.
- It is my responsibility to inform my counselor of any changes related to this application, such as changes in my address, income or employment.
- **Prior** written approval from my counselor is needed before Rehabilitation Services will pay for any services.
- Payment for some services may be based on financial need according to my personal or family income.
- I expressly give permission for information about me to be shared within the Department for Children and Families (DCF). Rehabilitation Services will also have access to information in my Social Security, Disability Determination, DCF, and employment records.
- No one will be discriminated against by Rehabilitation Services because of disability, race, religion, sex, color, national origin, length of residency in the state, or ancestry.
- I have received a Guide to VR services.

_____ _____
APPLICANT'S SIGNATURE DATE

_____ _____
PARENT'S, GUARDIAN'S OR LEGAL REPRESENTATIVE SIGNATURE DATE

_____ _____ _____ _____
PARENT, GUARDIAN, REPRESENTATIVE ADDRESS CITY STATE ZIP CODE

_____ _____ _____
PARENT, GUARDIAN, REPRESENTATIVE PHONE CELL PHONE EMAIL ADDRESS

Department for Children and Families
Rehabilitation Services

9/93

Health Assessment Questionnaire

Name:_____ Date of Birth: _____

Address:_____ Height:_____Weight_____

I have had:		Yes	No	Explain any "Yes" answers (problem - who treated - when)
1.	Problems with eyes, ears, nose, throat	☐	☐	
2.	Dizziness, fainting, blackout, convulsions, stroke, paralysis,	☐	☐	
3.	A head injury	☐	☐	
4.	Persistent bronchitis, asthma, emphysema, tuberculosis, or other problems with chest or lungs	☐	☐	
5.	High blood pressure, chest pain, heart attack, rheumatic fever, heart murmur, or other problems with heart or blood vessels	☐	☐	
6.	Ulcer, hernia, colitis, intestinal bleeding, or other problems with stomach, intestines, liver, or gall bladder	☐	☐	
7.	Problems with kidneys, bladder, prostate, reproductive organs, or venereal disease	☐	☐	
8.	Diabetes, thyroid, pituitary, adrenal, or other gland problems	☐	☐	
9.	Arthritis, low back pain, or other problems with spine, back or joints	☐	☐	
10.	Loss or paralysis of limb or other body parts	☐	☐	
11.	Tumors, leukemia, or cancer	☐	☐	
12.	Allergies, anemia, skin problems	☐	☐	
13.	Mental or emotional problems	☐	☐	
14.	Problems with reading, arithmetic, writing or speech	☐	☐	
15.	Problems with alcohol or drugs	☐	☐	
16.	Treatment for any physical or mental problems	☐	☐	
17.	Prescriptions for any drugs or medications	☐	☐	
18.	A brace, prosthesis, hearing aid or other device	☐	☐	

My recent medical records may be obtained from:
Name of Physician/Hospital: _____
Address: _____
Date of Last Exam: _____Reason:_____

I certify that all of the information I have given is true, correct and complete to the best of my knowledge.

_____ _____ _____ _____
Client's Signature Date Counselor's Signature Date

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A note about filling out W9s.

We are required to have a W9 on file with State Administration if any payments are to be made to a client.

Please make sure of the following:

Name- must match what is on your social security card.

Address- make sure this is where you would want any checks mailed.

Social Security number can be left blank if you are uncomfortable mailing the form with the number present.

Form must be signed by the client or guardian, if guardian signs please add "legal guardian" to signature.

Please return the W9 to us by mail only. We cannot accept JPEGS, photos/scans to email or faxes. It degrades the copy and will not be accepted by our administration.

Thanks

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

CONSUMER QUESTIONNAIRE

NAME: _____

(Please Print)

1. What is your reason for wanting to see a rehabilitation counselor? How can VR help you to obtain your employment goal?

2. Describe your disability and how it impacts your ability to work and to complete daily activities:

3. What are your strengths and interests that could lead to employment opportunities?

4. What is your employment goal?

5. Please provide the following information for all medical, mental health, probation/parole officer, drug/alcohol treatment provider, etc.

Name	Address	Type of Service Provided

6. Please list prescribed medications.

Medication	Side effects (if any)

7. Do you have a Ticket to Work? _____Yes _____ No
   Is it available for assignment to an Employment Network (EN)? _____ Yes _____ No
   If ticket has been assigned, which EN has it been assigned to? _____

8. Do you have a valid driver's license? _____ Yes _____ No
   What are you currently using for transportation? _____
   Do you have access to public transportation? _____Yes _____ No

9. Do you require childcare to participate in training or to become employed? _____ Yes _____ No
   Do you currently have a childcare provider? _____ Yes _____ No
   If yes, please provide name of provider/center: _____

10. Household information

Who lives with you?	Age	Relationship	Income

Work Record (Begin with your current or most recent job)

Employer______________________ Address ______________________

City ______________________ State ____________ Zip ______________

Start Date _____/_____/_____ End Date _____/_____/_____ Hourly Wage ______ Hrs per week ______

Supervisor ____

Job Duties ____

Job Title ______________________ Reason Left ______________________

List job duties (if any) you can no longer perform in this job: ______________________

Employer______________________ Address ______________________

City ______________________ State ____________ Zip ______________

Start Date _____/_____/_____ End Date _____/_____/_____ Hourly Wage ______ Hrs per week ______

Supervisor ____

Job Duties ____

Job Title ______________________ Reason Left ______________________

List job duties (if any) you can no longer perform in this job: ______________________

Employer______________________ Address ______________________

City ______________________ State ____________ Zip ______________

Start Date _____/_____/_____ End Date _____/_____/_____ Hourly Wage ______ Hrs per week ______

Supervisor ____

Job Duties ____

Job Title ______________________ Reason Left ______________________

List job duties (if any) you can no longer perform in this job: ______________________

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Medical Authorization for Disclosure to Release and Obtain Private Information

This release is set up for us to be able to request medical records from your doctor/clinic to aide us in determining your eligibility for services and determining your barriers to employment.

You will need to fill in your doctor's name or clinic name, address and phone number in the "Disclosure of information from" box.

You will also need to sign the form. Witness signature is only necessary for mental health records release. If you are under 18 or have a legal guardian, a parent or guardian signature is required.

Thank you for filing out and signing this form correctly, it will greatly reduce the amount of time it takes to obtain your medical records.

STATE OF KANSAS

Department for Children and Families - Rehabilitation Services (RS)

Release of Information

Authorization for Disclosure to Release and Obtain Private Information

NAME: (Last, First, MI)	SOCIAL SECURITY NUMBER XXX-XX-	BIRTHDATE

I authorize the disclosure of my private information, as follows:

☐ **Check this box to allow communication between these two parties below.**

Disclosure of information from: _____ Address or Comment: _____ Phone: Fax:	Disclosure of information to: Vocational Rehabilitation Attn: _____ Phone: 913-942-3303 Fax: 913-826-7583

The type and amount of information to be disclosed:

- ☑ Medical records including diagnoses, prognoses, treatment plans, medical recommendations, current general health status, medications and employment limitations imposed by disability. This includes, but not limited to general physical exam, visual reports, and audiological evaluations, etc. Limited to medical records from _____ to _____.
- ☑ Drug/alcohol treatment records
- ☐ HIV/AIDS – Related Information
- ☑ Psychiatric/Psychological testing/reports: including DSM V diagnosis, treatment records, clinical notes, discharge summaries & functional limitations to employment.
- ☐ Employment Information and Records including, but not limited to verification of wage earnings, hours, benefits, and performance
- ☐ Vocational information, including vocational evaluations, recommendations, employment barriers, plans, and progress reports.
- ☐ Criminal History Records, current legal system involvement
- ☐ Academic testing/Transcripts/Degree Analysis
- ☐ Educational Records (IEP/504/Behavioral Plan/Schedule)
- ☐ Financial Aid Award Letter
- ☐ Accommodation/Employment Needs
- ☐ Service Record Information
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

☑ **Electronic Information Exchange:** I authorize use of e-mail and/or other electronic devices by rehabilitation services for exchange of information with me. I understand that there are no security features in place to assure confidentiality.

The information identified above is necessary for: Determination of eligibility, planning, and coordination for rehabilitation services.

Authorization for Disclosure: (A photocopy or fax of this release is as effective as the original):

- I understand the information released by this authorization may include personally identifying information concerning physical and mental disabilities, alcohol/drug abuse, HIV/AIDS, medical history, criminal history, and educational/vocational records.
- I understand the authorization for disclosure allows verbal and written communication to the identified party above.
- I understand that this authorization for disclosure is voluntary. I understand that Rehabilitation Services will use the information disclosed for purposes of Vocational Rehabilitation Services and/or Pre-Employment Transition Services and will not be released to any other person, agency, or entity for purpose without my written permission except as required by Federal or State law.
- Parties to whom Rehabilitation Services provides information are prohibited under federal regulations (34 CFR 361 and/or 45 CFR Part 2) from further releasing the information without my express written consent. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the party receiving it. I also understand the specific rules governing Rehabilitation Services re-disclosure of information obtained under this release, which are identified in Rehabilitation Rights and Responsibilities document. Date upon which this authorization will expire: _____ I understand that I may revoke this release by notifying Rehabilitation staff at any time in writing and that it will automatically expire within THREE (3) years of the signature date listed below.

I certify that I agree to the uses and disclosures listed above and that I will receive a copy of this authorization.

Signature of Individual	Date
Signature Parent, Guardian, or Authorized Representative	Date

Print Name	Relationship	Witness Signature

NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING RS RECORDS

This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (34-CFR Part 361) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.

Overland Park Service Center
8915 Lenexa Drive
Overland Park, KS 66214

Kansas
Department for Children
and Families

Phone: (913) 826-7300
Fax: (913) 826-7583
www.dcf.ks.gov

Laura Howard, Secretary

Laura Kelly, Governor

Communication Authorization for Disclosure to Release and Obtain Private Information

This release is set up for us to be able to speak with anyone you designate about your case. It allows for two-way communication and sharing information.

You will need to fill in the designated person's name, address and phone number in the "Disclosure of information from" box.

You will also need to sign the form. Witness signature is only necessary for mental health records release. If you are under 18 or have a legal guardian, a parent or guardian signature is required.

Thank you for filing out and signing this form correctly, it is required before we can speak with third parties about your case.

STATE OF KANSAS

Department for Children and Families - Rehabilitation Services (RS)

Release of Information

Authorization for Disclosure to Release and Obtain Private Information

NAME: (Last, First, MI)	SOCIAL SECURITY NUMBER XXX-XX-	BIRTHDATE

I authorize the disclosure of my private information, as follows:

☑ **Check this box to allow communication between these two parties below.**

Disclosure of information from: _____ Address or Comment: _____ Phone: Fax:	Disclosure of information to: Vocational Rehabilitation Attn: _____ Phone: 913-942-3303 Fax: 913-826-7583

The type and amount of information to be disclosed:

- ☐ Medical records including diagnoses, prognoses, treatment plans, medical recommendations, current general health status, medications and employment limitations imposed by disability. This includes, but not limited to general physical exam, visual reports, and audiological evaluations, etc. Limited to medical records from _____ to _____.
- ☐ Drug/alcohol treatment records
- ☐ HIV/AIDS – Related Information
- ☐ Psychiatric/Psychological testing/reports: including DSM V diagnosis, treatment records, clinical notes, discharge summaries & functional limitations to employment.
- ☐ Employment Information and Records including, but not limited to verification of wage earnings, hours, benefits, and performance
- ☐ Vocational information, including vocational evaluations, recommendations, employment barriers, plans, and progress reports.
- ☐ Criminal History Records, current legal system involvement
- ☐ Academic testing/Transcripts/Degree Analysis
- ☐ Educational Records (IEP/504/Behavioral Plan/Schedule)
- ☐ Financial Aid Award Letter
- ☐ Accommodation/Employment Needs
- ☐ Service Record Information
- ☑ Other: Open communication with VR regarding client's case,
- ☐ Other: goals, services, rehabilitation needs, accommodations,
- ☐ Other: plans, concerns and well being.

☑ **Electronic Information Exchange:** I authorize use of e-mail and/or other electronic devices by rehabilitation services for exchange of information with me. I understand that there are no security features in place to assure confidentiality.

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Authorization for Disclosure: (A photocopy or fax of this release is as effective as the original):

- I understand the information released by this authorization may include personally identifying information concerning physical and mental disabilities, alcohol/drug abuse, HIV/AIDS, medical history, criminal history, and educational/vocational records.
- I understand the authorization for disclosure allows verbal and written communication to the identified party above.
- I understand that this authorization for disclosure is voluntary. I understand that Rehabilitation Services will use the information disclosed for purposes of Vocational Rehabilitation Services and/or Pre-Employment Transition Services and will not be released to any other person, agency, or entity for purpose without my written permission except as required by Federal or State law.
- Parties to whom Rehabilitation Services provides information are prohibited under federal regulations (34 CFR 361 and/or 45 CFR Part 2) from further releasing the information without my express written consent. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the party receiving it. I also understand the specific rules governing Rehabilitation Services re-disclosure of information obtained under this release, which are identified in Rehabilitation Rights and Responsibilities document. Date upon which this authorization will expire: _____ I understand that I may revoke this release by notifying Rehabilitation staff at any time in writing and that it will automatically expire within THREE (3) years of the signature date listed below.

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Signature of Individual	Date
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Department for Children and Families
NOTICE OF USE OF PRIVATE HEALTH INFORMATION
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
PLEASE REVIEW IT CAREFULLY

Para obtener la versión en español de este aviso contacte a la Oficina del Área (enumeradas al final de este documento) que atiende al condado de su residencia

The Department for Children and Families(DCF) understands that information we collect about you and your health is personal. Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. The following is a notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at DCF, please contact your local representative, or DCF Privacy Officer, indicated on the contact list below.

A. How DCF May Use or Disclose Your Health Information.
The following categories describe the ways DCF may use and disclose your health information, as part of our normal operations to assist you, without asking you for permission. For each category of uses and disclosures, we will explain what we mean and present some examples. In each category we will only disclose the minimum amount of information needed to accomplish the task. Not every use or disclosure in a category will be listed. However, the ways we are permitted to use and disclose information will fall within one of the categories.

1. Treatment. We may use or disclose health information about you to provide the necessary treatment for you. For example, if you are a patient of one of the state hospitals we may use medical information about you to provide you with treatment or services. We may disclose medical information about you to qualified mental health professionals; qualified mental retardation professionals; qualified counselors; or technicians. Your treatment team members will internally discuss your medical/health information in order to develop and carry out a plan for your services. Different departments of the facility also may share medical/health information about you in order to coordinate the different things you need, such as prescriptions, medical tests, special dietary needs, respite care, personal assistance, day programs, etc. We also may disclose medical/health information with people outside the hospital who may be involved in your medical care, but only the minimum necessary amount of information will be used or disclosed to carry this out.

2. Payment Functions. We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services received from providers, determine program responsibilities for benefits, and to coordinate program benefits. For example, payment functions may include reviewing the medical necessity for health care services, reviewing a plan of care for payment to one of DCF community partners such as a Community Developmental Disability Organization, a Community Mental Health Center, a Regional Alcohol and Drug Abuse Treatment Center, just to mention a few. We may also use or disclose health information to facilitate proper payment for treatment such as providing your Medicaid identification number to a health care provider, a pharmacy or other health provider who has an agreement with DCF to provide services to our clients/patients.

3. Health Care Operations. We may use or disclose health information about you to carry out necessary program related activities. Such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; conducting or arranging for medical or program reviews, legal services, audit services, and fraud and abuse detection programs; business planning, management and general administration; case management and care coordination; accreditation, certification, licensing, or credentialing activities.

4. Required by Law. As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action, a child custody hearing, or establishing paternity.

5. Public Health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

6. Disclosures about Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information about an individual who we reasonably believe is a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

7. Health Oversight Activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the Agency programs. Examples would be sharing health information with the Kansas Department of Health and Environment for their licensure activities involving child care centers or nursing home facilities.

8. Judicial and Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

9. Law Enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, or complying with court order or subpoena and other law enforcement purposes.

10. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to coroners, medical examiners and funeral directors, if, for example, it is necessary to identify a deceased person or determine the cause of death.

11. Organ and Tissue Donation. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues, as necessary.

12. Public Safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

13. **National Security**. We may disclose your health information for military, national security, prisoner and government benefits purposes.

14. **Worker's Compensation**. We may disclose your health information as necessary to comply with Worker's Compensation or similar laws.

15. **Marketing**. We may provide health information to other state or local agencies who may contact you to give you information about health related benefits and services that may be of interest to you.

16. **Appointment Reminders**. We may use and disclose your health information to contact you with appointment reminders for treatment or services provided by DCF.

17. **Research Activities**. We may disclose health information about you for research purposes.

B. When DCF May Not Use or Disclose Your Health Information.
Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time to the local contact person, or DCF Privacy Officer, indicated on the contact list below. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

C. Statement of Your Health Information Rights
1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. DCF is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the local contact person, or DCF Privacy Officer, indicated on the contact list below.

2. **Right to Request Confidential Communications**. You have the right to receive your health information through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit your request in writing to the local contact person, or DCF Privacy Officer, indicated on the contact list below.

3. **Right to Inspect and Copy**. You have the right to inspect and copy health information about you that may be used to make decisions about your treatment or benefits, with the exception of psychotherapy notes or information gathered for and used in legal or administrative proceedings. To inspect and copy such information, you must submit your request in writing to the local contact, or DCF Privacy Officer, indicated on the contact list below. If you request a copy of the information we may charge you a reasonable fee to cover expenses associated with your request.

4. **Right to Request Amendment**. You have the right to request that DCF amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing to the local contact, or DCF Privacy Officer, indicated on the contact list below.

5. **Right to an Accounting of Disclosures**. You have the right to receive a list of "accounting of disclosures" of your health information made by us, except that we do not have to account for disclosures made for purposes described in Section A 1-3, of this document, disclosures authorized by you or disclosures made to you. To request this list of disclosures you must submit your request in writing to the local contact person, or DCF Privacy Officer, indicated on the contact list below.

6. **Right to Paper Copy**. You have a right to receive a paper copy of this Notice Of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the local contact, or DCF Privacy Officer, indicated on the contact list below. You may also obtain a copy of this Notice at our website, www.DCFkansas.org

D. Changes to this Notice of Privacy Practices
DCF reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, DCF is required by law to comply with the current version of this Notice.

E. Complaints
If you believe your privacy rights have been violated you may take the following actions:

- File a complaint with DCF by contacting the DCF Privacy Officer, or the local contact, in writing at the address indicated on the contact list below, or
- File a written complaint with the Office for Civil Rights, Secretary of the Department of Health and Human Services, 601 East 12th Street - Room 248, Kansas City, Missouri 64106.

You will not be retaliated against for filing a complaint. Your health care services and/or benefits will not be affected in any way.

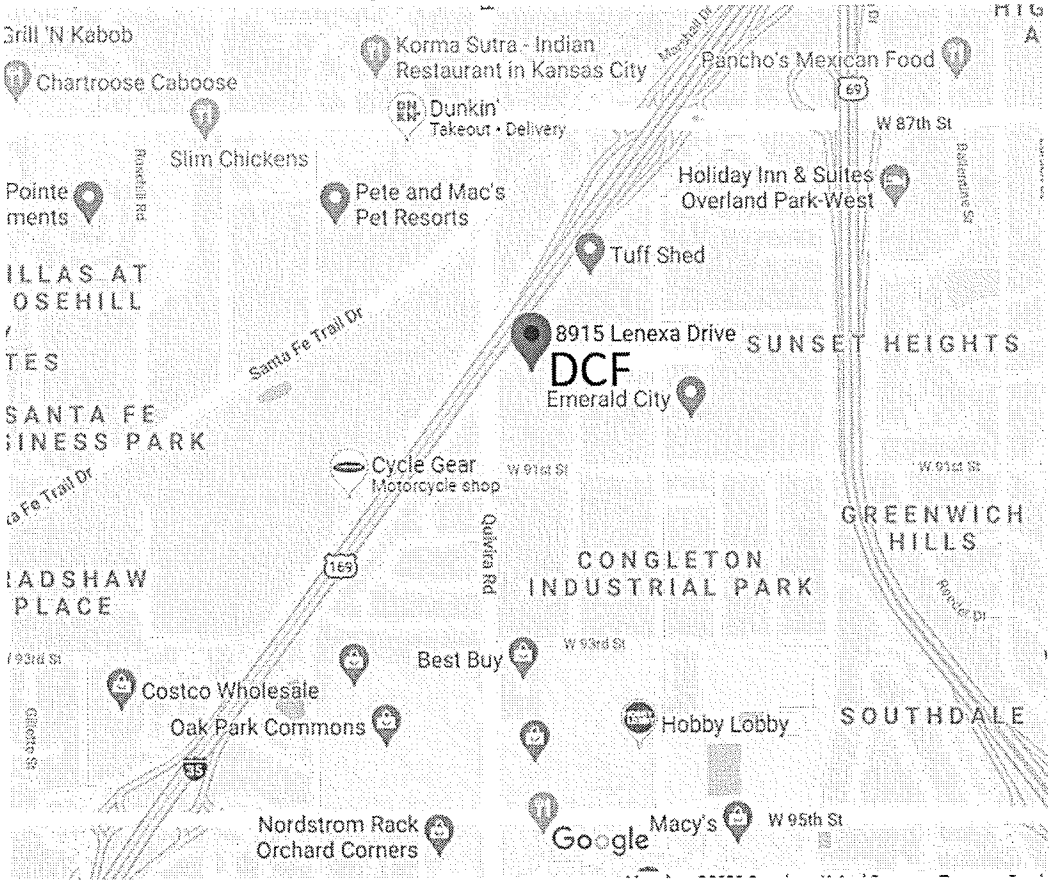
HIPAA Local Contact	Telephone #	Counties Served
Kansas City Metro Region, Customer Service 1901 Delaware P.O. Box 590 Lawrence, KS 66044-0590	(785) 832-3710 (785) 843-0291 (FAX)	Douglas, Atchison, Johnson, Leavenworth, Wyandotte

This Notice of Privacy Practice is effective April 14, 2003.

DIRECTIONS TO OVERLAND PARK AREA

DEPARTMENT FOR CHILDREN AND FAMILIES OFFICE

DCF is located at 8915 Lenexa Drive, Overland Park 66214 between 87th and 95th Streets.
Lenexa Drive is the frontage road that runs parallel to I-35 on the EAST side.



If you are traveling from south of 95th Street (such as from Olathe):

Take I-35 North towards KANSAS CITY
Take the 95th Street exit (#224)
Turn RIGHT (east) onto 95th Street
Turn LEFT (north) onto Monrovia, go past SAM's club, bearing right
Monrovia becomes Lenexa Drive.
The DCF office is approximately 3 tenths of a mile on your right side.

If you are traveling from the north:

Take I-35 south towards WICHITA
Take the 95th Street exit (#224)
Turn left (east) onto 95th Street to the first intersection-Monrovia
Turn LEFT (north) onto Monrovia, go past SAM's club, bearing right
Monrovia becomes Lenexa Drive.
The DCF office is approximately 3 tenths of a mile on your right side.