APPLICATION FOR VOCATIONAL REHABILITATION PROGRAM

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
VOCATIONAL REHABILITATION
SFN 180 (5-2022)

Assigned Caseload

I am requesting services through Vocational Rehabilitation (VR) because I intend to become employed or continue in employment.

Name (Last, First, MI)	Social Security Number

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to North Dakota Century Code 43-50-02. The social security number is used for identification purposes to access quarterly wage records and report to the agency's federal funding source in compliance with the Workforce Innovation and Opportunity Act. Penalty for the applicant not including the social security number on their application may cause the application to not be processed.

Preferred Name (if different from above)	Suffix (Jr./Sr. etc.)

Gender	Date of Birth
☐ Male ☐ Female ☐ Prefer not to disclose ☐ Self Identity _____	

Previous Last Name

Current Address

City	State	ZIP Code	County

Mailing Address (if different from above)

City	State	ZIP Code

Primary Telephone Number	Secondary Telephone Number
☐ Land line ☐ Cell	☐ Land line ☐ Cell

E-Mail Address

Race/Ethnicity (check all that apply)

- ☐ White/Caucasian
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino
  NOTE: If Hispanic or Latino is selected, at least one other race must also be selected.
- ☐ Native Hawaiian or Other Pacific Islander

English Speaking Ability	English Reading Ability
☐ Functional ☐ Limited	☐ Functional ☐ Limited

Primary Language

☐ English ☐ Sign Language ☐ Spanish ☐ Other _____

Preferred Correspondence Format

☐ Braille ☐ Email ☐ Large Print ☐ Regular Print

My disability is:

Describe how your disability affects your ability to obtain and/or maintain employment.

PERSONAL CONTACT List below the name of an individual (other than spouse) who will always know how to contact you.

Name (Last, First, MI)			
Relationship	E-Mail Address		
Mailing Address			
City		State	ZIP Code
Primary Telephone Number	Secondary Telephone Number		

Do you have a legal guardian? ☐ Yes ☐ No	If Yes, Complete the Following
Name (Last, First, MI)	
Mailing Address	

City		State	ZIP Code
Primary Telephone Number	E-Mail Address		

_____ **Initial here to indicate your permission to contact these people, if necessary**

The Division of Vocational Rehabilitation may exchange with the programs authorized under the Workforce Innovation and Opportunity Act the following information: name, social security number, program status, and demographic data including date of birth, race, and gender. This information is necessary for the purpose of collecting, reporting and analyzing data, as well as to facilitate access to services or programs offered. Other than these situations, information will only be released to sources upon my individual written consent as authorized by law.

I intend to become employed or continue my current employment and will actively work with my VR counselor.

Applicant Signature	Date
Parent Signature (If Applicant is Under Age 18)	Date
Legal Guardian Signature	Date