APPLICATION FOR VOCATIONAL REHABILITATION PROGRAM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
VOCATIONAL REHABILITATION
SFN 180 (1-2025)

Clear Fields

Assigned Caseload

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

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number (SSN) is requested for accurate identification pursuant to U.S. Code 552a(8)(A) (Privacy Act of 1974). The SSN 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. After your eligibility for services has been determined and it is time to develop your Individualized Plan for Employment, we will need your SSN. Failure to provide your SSN at that time would prohibit the agency from being able to gather required employment verification information and may result in your case being closed.

Legal Name (Last, First, MI)			Social Security Number
Preferred Name (if different from above)			Suffix (Jr./Sr. etc.)
Gender ☐ Male ☐ Female ☐ Prefer not to disclose ☐ Self identify (specify): _____			Date of Birth
Previous Name(s)			
Current Address			
City	State	ZIP Code	County
Mailing Address (if different from above)			
City	State	ZIP Code	
Primary Telephone Number ☐ Cell ☐ Landline	Secondary Telephone Number ☐ Cell ☐ Landline		
Email Address			

Race/Ethnicity (check all that apply)

- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or 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 ☐ Functional ☐ Limited	English Reading Ability ☐ Functional ☐ Limited

Primary Language
☐ English ☐ Sign Language ☐ Spanish ☐ Other (specify): _____

Preferred Correspondence Format
☐ Braille ☐ Email ☐ Large Print ☐ Regular Print

Methods of Communication (check all that apply)
☐ In Person ☐ Virtual ☐ Phone ☐ Text Message ☐ Other (specify): _____

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

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 acknowledge that Vocational Rehabilitation (VR) staff and I have reviewed:

1. The following information:
   - the purpose of the VR program - which is employment.
   - the need for additional information, if necessary.
   - confidentiality and its limitations.
   - whom to contact if my counselor is unavailable.

2. Electronic Communications. You may request the Department's VR Program to communicate with you electronically through unencrypted (unsecure) emails, text messages, or both. The privacy and security of electronic communications cannot be guaranteed. There is risk that any confidential information contained in such communications may be misdirected, disclosed to, or intercepted by an unauthorized recipient. You should not agree to electronic communications unless you are willing to accept these risks.

   All electronic communications including those containing confidential information are unencrypted (unsecure). We will rely on the contact information you provide. You are responsible for providing the correct information and notifying us of any changes to your information. The Department is not liable for electronic communications that are not received due to technical failure or for improper disclosures of confidential information that are not a result of our negligence. The Department is not responsible for any fees imposed by your email or text message service provider. Electronic communications may be included in your VR case file.

   The Department cannot guarantee that an electronic communication will be read and responded to within a specific period of time. The Department does not monitor electronic communications during non-business hours.

Select the type of unencrypted electronic communications you wish to receive (check all that apply)
☐ Email ☐ Text Messages

_____ Initials I request and consent to receive the electronic communications selected above. I understand this request applies only to the VR Program. I understand that unencrypted (unsecure) means the added security protections that help safeguard the contents of electronic communications are removed.

3. My rights and responsibilities under the VR program. I understand these rights and responsibilities, and I agree to abide by them.

- I intend to become employed, maintain in, or advance in employment and will actively work with and maintain regular contact with my VR counselor.
- The information regarding the North Dakota Client Assistance Program has been provided to me and I understand that I am entitled to work with them should a disagreement concerning services arise between my VR counselor and me.

Applicant's Legal Signature	Date
Parent signature (If Applicant is Under Age 18)	Date
VR Staff Signature	Date
Guardian or Parent Signature	Date