APPLICATION FOR VOCATIONAL AND EMPLOYMENT SERVICES

Michigan Department of Health and Human Services
Michigan Rehabilitation Services

For MRS office use only
Date application received

Note: Your case is considered an open case when (1) the entire application is completed and signed by you and a MRS counselor, and (2) you are available to take part in the eligibility determination process.

PART 1 (to be completed by customer)

Personal Information			
Last Name:	First Name:	Middle Name	Social Security Number:
Name you want to be called:	Former Last Name:		Birth Date:
Gender ☐ Male ☐ Female ☐ Do not wish to self-identify			
Mailing Address:			
City:		State	Zip Code:
County:		Email Address:	
Primary Phone Ext. ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Video Phone			
Second Phone Ext. ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Video Phone			
How did you hear about MRS?			
Were you a customer of MRS in the past? ☐ Yes ☐ No		When?	What Office?
Characteristics			
Are you a citizen of the U.S.? If no, what type of Visa do you have? **A copy of your Visa is required.** ☐ Yes ☐ No			
Do you have a Work Permit? Type of Permit: ☐ Yes ☐ No			
What is your race/ethnicity (check all that apply)? ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Arab ☐ Asian ☐ Hmong ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander			
Do you consider yourself to be multi-racial? ☐ Yes ☐ No			

Customer Name _____

Do you have a legal Guardian? **A copy of guardianship documents is required.** ☐ Yes ☐ No	If yes, what is Guardian's Name:
What is Guardian's phone number? ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Video Phone	
Do you have a Michigan Driver's License? ☐ Yes ☐ No	State of Michigan ID? ☐ Yes ☐ No

Your Needs

What language do you use most of the time?

☐ English ☐ Spanish ☐ Arabic ☐ American Sign Language

☐ Other – Explain:

What language do you use for printed documents?

☐ English ☐ Spanish ☐ Arabic

☐ Other – Explain:

Do you need an interpreter, large print or other type of help to work with MRS

☐ Yes ☐ No Explain:

Information about your disability

What is your physical or mental disability? (Examples: Depression, anxiety, substance abuse, learning disability, ADD, ADHD, diabetes, epilepsy, paraplegia, back injury, etc.)

Does your disability affect your ability to?

☐ Stand	☐ Walk	☐ Sit	☐ Lift	☐ Bend
☐ See	☐ Hear	☐ Read	☐ Write	☐ Use Hand or Feet
☐ Concentrate	☐ Remember	☐ Learn	☐ Understand	☐ Handle Stress
☐ Communicate	☐ Control Emotions	☐ Work with Others		

☐ Other – Explain:

STOP

PAGES 3 - 6 OF THE APPLICATION WILL BE COMPLETED WITH YOUR MRS COUNSELOR

Customer Name _____

PART 2 (to be completed with your MRS counselor)

Basic Information

What is your current living arrangement?

- ☐ Adult/Youth correctional facility
  - When does your Parole/Probation end? _____
  - Parole/Probation Office: _____
- ☐ Community residential/Group home
- ☐ Halfway house
- ☐ Homeless/shelter
- ☐ Mental health facility
- ☐ Nursing home
- ☐ Private residence (applicant only, with family or with another person)
- ☐ Rehabilitation Facility
- ☐ Substance abuse treatment center
- ☐ Other: _____

What is your marital status?

☐ Single/Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Are you a Veteran

☐ Yes ☐ No

Are you a migrant or seasonal farmworker?

☐ Yes ☐ No

Are you currently a registered voter?

☐ Yes ☐ No

If you are eligible to vote, would you like to register to vote?

☐ Yes ☐ No

Income

(Please check Yes or No and enter monthly amount, if applicable)

Do you receive:	Yes (✓)	No (✓)	Monthly Amount
Social Security Disability Insurance (SSDI)	☐	☐	
Supplemental Security Income (SSI)	☐	☐	
Family Independence Program (FIP) also known as Temporary Assistance to Needed Families (TANF)	☐	☐	
If yes, will you run out of TANF within 2 years?	☐	☐	
State Disability Assistance (SDA) also known as General Assistance (GA) in some areas	☐	☐	
Unemployment Insurance Benefits	☐	☐	
Veterans Disability (VA)	☐	☐	
Workers' Compensation	☐	☐	
Other types of Public Assistance (Examples: government payments for retirement or survivor benefits, SSA dependent or widower benefits, any other temporary payments)	☐	☐	
Other Disability Income: ☐ Long Term Disability (LTD) ☐ Auto No-Fault	☐	☐	
Non-Cash Income – Food Assistance (also known as Bridge Card)	☐	☐	

Customer Name _____

What is your primary source of income at Application?

☐ Personal income (employment earnings, interest dividends, rent, retirement including Social Security)

☐ Public Support (SSI, SSDI, TANF, etc.) Explain: _____

☐ Family and friends ☐ Private Relief Agency ☐ Public Institution – Tax Supported

☐ Worker's Compensation

☐ All other sources (e.g., private disability insurance and private charities.

Medical Insurance

What is your current medical coverage? (Please check all that apply.)

☐ Medicaid ☐ Medicare ☐ Affordable Care Act ☐ None

☐ Private insurance through own employer. Provider: _____

☐ Not yet eligible for private insurance through current employer.

☐ Private insurance from other means. (Example: insurance is provided by a parent or a spouse.)

Name of Insurance Company: _____

☐ Public Insurance from other source.

Name of Insurance Company: _____

Disability Related Information

Who is providing applicant's treatment and what is provider's address? (Name of Physician, Therapist, Case Manager, etc.) – If more room is needed, please add additional pages.

Have you ever been treated or hospitalized because of your disability?	☐ Yes	☐ No
Are you currently receiving disability related treatment?	☐ Yes	☐ No
Have you received disability related treatment in the past?	☐ Yes	☐ No
Are you currently taking any medications?	☐ Yes	☐ No

List the medications you are taking – if more room is needed, please add additional pages:

Education

If you are presently attending or are enrolled in a high school/post high school educational or training program, enter name of school: _____

If you are enrolled in Kindergarten-12 (K-12) education system, what is the Expected Date of Exit from school: _____

Do you have or are you receiving help or support for your disability in school (grades K-12)?

☐ IEP/Special Education Services and/or 504 Plan ☐ No

Degrees and/or certificates earned:

Customer Name _____

If you are currently enrolled in school, what grade are you in?

What is the highest level of education you have reached?

- ☐ Elementary ed. (grades 1-8)
- ☐ Secondary ed. (grades 9-12), no high school diploma
- ☐ High school diploma or equivalency (GED, home schooled)
- ☐ Certificate of Completion or Certificate of Attendance (Special Ed.)
- ☐ Vocational/Technical Certificate or License
- ☐ Post-secondary education, no degree or certificate
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Any Degree Above Master's (PH.D., Ed.D, J.D.)

Employment Information

What is your Employment Status? ☐ Working ☐ Not Working

What are your job interests and what services are you requesting from MRS?

Do you have child care needs?
☐ Yes ☐ No

What type of transportation do you use?
☐ Own Car ☐ Bus ☐ Other: _____

Have you ever been convicted of a felony or misdemeanor?
☐ Yes ☐ No

Are there limits on the kinds of jobs you can do or where you can work due to a felony or misdemeanor conviction or other legal issues?
☐ Yes ☐ No

Work History including Volunteer Work (approximate dates and earnings are needed) – Please list current or more recent job FIRST. If more room is needed, add additional pages.

Job 1 – most recent

Employer:	Job title:	
Address:		
Phone Number:	Start Date:	End Date:

Job Duties:

Was this seasonal employment? If yes, when did you work (example: 6/yyyy-9/yyyy)
☐ Yes ☐ No

Number of Hours Worked?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Last Salary/Pay Rate

Customer Name _____

Reason for Leaving:		
Job 2		
Employer:	Job title:	
Address:		
Phone Number:	Start Date:	End Date:
Job Duties:		
Was this seasonal employment? ☐ Yes ☐ No	If yes, when did you work (example: 6/yyyy-9/yyyy)	
Number of Hours Worked? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly		Last Salary/Pay Rate
Reason for Leaving:		
Emergency Contacts (Examples: Family, Friends, Probation Officer, etc.)		
Name:	Relationship:	
Phone Ext. ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Text ☐ Video Phone		
Name:	Relationship:	
Phone Ext. ☐ Voice ☐ TTY ☐ Fax ☐ Cell ☐ Text ☐ Video Phone		

Customer Name _____

APPLICANT: DO NOT SIGN AND DATE THIS APPLICATION UNTIL PAGES 1-6 HAVE BEEN COMPLETED AND REVIEWED WITH YOUR MRS COUNSELOR.

I have received a copy of the following brochures or the Six Steps to Vocational Rehabilitation Services and the information contained within the brochures has been explained to me:

- "Your Rights and Responsibilities as a Customer of MRS"
- "How to Appeal Decisions Made by Michigan Rehabilitation Services"
- "Client Assistance Program"

Applicant's Initials: _____ Date: _____

VERIFICATION OF ACCURACY: I declare that the statements made on this application are true and correct.

Applicant's Initials: _____ Date: _____

I understand that the purpose of receiving vocational rehabilitation services is to help me get or keep a job. I understand that I must be found eligible for the services that I require. At this time, I am applying for vocational rehabilitation services and would like to take part in the process to see if I am eligible for services.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent or Legal Guardian, if applicable Date

The application has been reviewed, the applicant has been provided orientation to MRS services, and their rights and responsibilities have been discussed.

_____ _____

Signature (MRS Counselor) Date