



## J. VESID OR CBVH REFERRAL FORM AND CONTACTS

This Appendix contains:

- The Transition Referral Transmittal sheet that districts can use to refer students who meet referral criteria to the local VESID or CBVH offices. It may be completed by hand or typewritten. Please complete it legibly in black or other dark ink. A student signature on the form (plus the signature of the parent or legal guardian, as appropriate) will constitute an application for services.
- Lists of CBVH and VESID District Offices for phone or written communication.

Remember to attach selected documents to the transmittal package that will assist VESID or CBVH to expedite determining eligibility, and planning vocational rehabilitation services that coordinate with district efforts in this regard.

In the near future, districts using the Part 200 Management System may be able to transmit referral data, applications and selected records electronically to VESID offices. Please look for future announcements, or after June 1994, please call VESID's Technology Unit at 518-486-4609 for further information.

## Authorization to Release / Obtain Information

(Please read instructions on page two before completing this form.)

VES-22 (09/03)

CONSUMER NAME	CONSUMER ID NUMBER
CONSUMER ADDRESS <i>[include street (apartment number or building, if applicable), city, state, zip]</i>	
<p>The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) has <i>my</i> permission to release or obtain information indicated in item #1 below. This information may include reports about <i>my</i> physical or mental condition, school records, facts necessary to determine <i>my financial need, or other information that VESID needs to determine my eligibility</i> and to provide vocational rehabilitation services. I understand that this information will be treated as confidential and privileged and will only be used for the purpose of obtaining services offered through VESID.</p> <p>I can change my mind about this release, by telling VESID in writing that I do not want any further information to be given out. I understand that information disclosed according to this consent may be subject to redisclosure and will no longer be subject to the HIPPA privacy requirements. This will not affect actions already taken with <i>my</i> permission.</p> <p>My permission to release or obtain information expires on date _____ or no later than one year from the date of signature, whichever is sooner.</p>	
1. What information is to be released or obtained? <i>(Be specific.)</i>	
Transcripts, Vocational Assessment, Psychological, Psychiatric (if available), IEP, Health Record, Social History, PT/OT/Speech Record	
2. Who is releasing this information? <i>(Insert the full name of this person or organization.)</i>	
Oneida County BOCES Special Education Department	
3. Who is receiving this information? <i>(Insert complete information about this person.)</i>	
Name: Ann Colgan; Joanne Donaruma	
Title: VESID Counselor; ARC Supported Employment Director	
Address: Genesee St. State Office Building, Utica, NY 13501; 245 Genesee St., Utica, NY 13502	
4. Why is this information needed?	
To facilitate the implementation of Transition planning and delivery of services.	

*I have read all of the information on this form. I understand and agree to what it says.*

Consumer or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records. Form VES-540, *Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Alcoholism or Substance Abuse*, must be attached to this form when necessary.

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its educational programs, services and activities. Inquiries concerning this policy of nondiscrimination should be directed to the Department's Office for Diversity, Ethics and Access, Room 130, Education Building, Albany, NY 12234

Please return the completed form to:

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of Vocational and Educational Services  
for Individuals with Disabilities (VESID)

### Application for VR Services

Please print or type all entries

VES-04 (11/04)

NAME Last			First			Middle Initial			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
If your school, health, or any other records are listed under another name, then enter the name(s) here:			Last			First			Middle Initial	
MAILING ADDRESS			Street			Apartment Number				
City		State		ZIP + 4 Code		County		SOCIAL SECURITY NUMBER		
PHONE NUMBER(s) where we can reach you or leave a message		Best time to call		DATE OF BIRTH						
1. ( )		1.		Month		Day		Year		
Area Code		Area Code		2.						
Race/Ethnicity – Choose ALL that apply. If left blank VESID will complete. If Hispanic or Latino is checked please check additional box.			<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Hispanic or Latino					
			<input type="checkbox"/> Asian (Includes Indian Subcontinent)		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander					
			<input type="checkbox"/> Black or African American		<input type="checkbox"/> White					
What is your disability?			Who referred you to us?		MARITAL STATUS		1 Married		3 Divorced	
					<input type="checkbox"/>		2 Widowed		4 Separated	
							5 Never Married			
I hereby apply for rehabilitation services:			Signature of applicant, parent, or legal guardian				Date			
<b>X (sign. here)</b>										

... Please answer the questions below and on the back of this form. ...

While you do not have to answer these questions now, your answers will help VESID process your application.

Have you ever received services from VESID or its former name, the Office of Vocational Rehabilitation (OVR)?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you now receiving services from one or more agencies?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you are, indicate the name(s) and address(es) _____		
_____		
Describe how your disability limits your ability to work.		
What services are you seeking from VESID?		

Persons applying for or receiving rehabilitation services have the right to have any actions or decisions of this Office reviewed. A description of the review process and form can be obtained from any VESID District Office.

Are you disabled because of a work-related injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Check the <input type="checkbox"/> SSI <input type="checkbox"/> SSDI benefit(s) you <input type="checkbox"/> Workers <input type="checkbox"/> Other now receive <input type="checkbox"/> Compensation  Do you regularly see a doctor or clinic about your disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes,' indicate date of last visit _____ Also, if you see one or more doctors or clinics about your disability, list in the box below their names and addresses.
Do you use any assistive devices or aids?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a valid driver's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have access to a motor vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you able to leave your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and address of doctor(s) and clinic(s)		

**Circle the highest grade you have successfully completed, and check the applicable box(es)**

1	2	3	4	5	6	7	8	9	10	11	12	GED, or High School Equivalency Diploma	<input type="checkbox"/> Yes <input type="checkbox"/> No	13	14	15	16	17	20	
Elementary								High School						College				One or More Years in Graduate School		Doctorate

Special Education  Yes  No      Do you now attend high school?  Yes  No      Indicate college degree(s) earned \_\_\_\_\_

Name and address of school you last attended

**List below other people in your household**

Full Name	Age	Their Relationship to You

**List below the person or persons VESID can contact in an emergency**

Name	Address	Phone

**List below your work history (Include attachments, as necessary)**

Employer Name and Address	Date Employed		Weekly Earnings	Job title and duties, and Reason for Leaving
	From	To		

**All information will be kept confidential and is subject to verification**

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## Information Release Authorization

VES-21 (2/99)

Name: \_\_\_\_\_  
*Print full name*

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) has my permission to release or obtain information from agencies [including the Client Assistance program (CAP)], individuals, or employers as are concerned with my vocational rehabilitation. This information may include reports about my physical or mental condition, official school records, facts necessary to determine my financial need, or other information that VESID needs to determine my eligibility and to provide vocational rehabilitation services.

I understand that:

- All such information will be treated as confidential and privileged;
- The information will be used only for the purpose of obtaining services offered through VESID;
- I can withdraw my permission to release or obtain information by writing to VESID (this will not affect actions already taken with my permission); and
- VESID may need to use the information to administer the vocational rehabilitation program

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*