California State Agency

Elizabeth Mortensen
Student Service Counselor
Evangelina Herrera
Vocational Rehabilitation Counselor

Department of Rehabilitation: Student Services

Looking at different careers

Work Experience

Applying to College or FAFSA

Learning Job Skill

Self-Advocacy

Transition to Adult Services

Spring Semester of high school transition from Student Services to Adult Services

Adult Services available tuition, books and supplies or employment services.

Department of Rehabilitation: Support with School

- Counseling and Guidance
- Tuition
- Books
- Supplies
- Transportation
- Assistive Technology


A Course on...
Welding
and Cutting Metals
Start Your Own High-Paying Career In Welding With This Welding Course


CUSTOMER SERVICE
NEXT EXIT


DATA ENTRY
Skillbuilding and Applications


EXPERT
FORKLIFT
TRAINING


DOR
Vocational Training

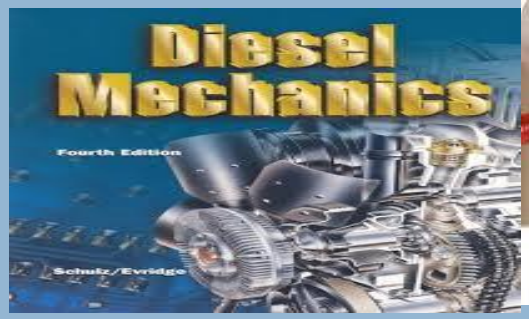

SOLAR TRAINING


Food Service
Training Program


AUTO MECHANIC
SCHOOLS


OPTICAL
DISPENSER


Truck Driver Training


Diesel
Mechanics
Fourth Edition
Schultz/Eveidge


PLUMBING

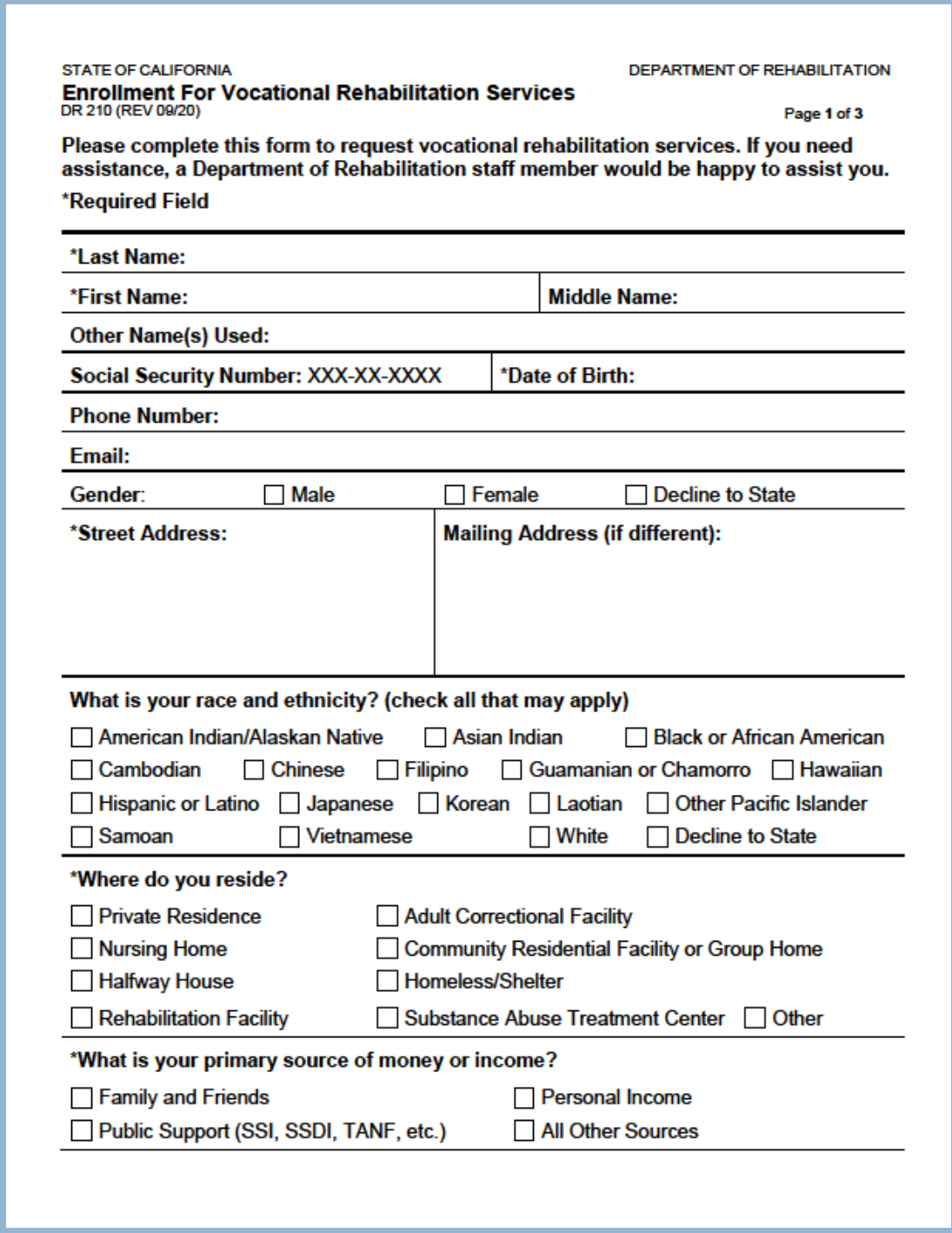

ELECTRICAL APPRENTICESHIP

Department of Rehabilitation: Employment Services

A different path to a new career!

Department of Rehabilitation: Support to Maintain You Job

Enrollment for Vocational Rehabilitation Services (DR210)



STATE OF CALIFORNIA — DEPARTMENT OF REHABILITATION

Enrollment For Vocational Rehabilitation Services

DR 210 (REV 09/20)

Please complete this form to request vocational rehabilitation services. If you need assistance, a Department of Rehabilitation staff member would be happy to assist you.

***Required Field**

***Last Name:**

***First Name:** | **Middle Name:**

Other Name(s) Used:

Social Security Number: XXX-XX-XXXX | ***Date of Birth:**

Phone Number:

Email:

Gender: ☐ Male ☐ Female ☐ Decline to State

***Street Address:** | **Mailing Address (if different):**

What is your race and ethnicity? (check all that may apply)

☐ American Indian/Alaskan Native ☐ Asian Indian ☐ Black or African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hawaiian
☐ Hispanic or Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to State

***Where do you reside?**

☐ Private Residence ☐ Adult Correctional Facility
☐ Nursing Home ☐ Community Residential Facility or Group Home
☐ Halfway House ☐ Homeless/Shelter
☐ Rehabilitation Facility ☐ Substance Abuse Treatment Center ☐ Other

***What is your primary source of money or income?**

☐ Family and Friends ☐ Personal Income
☐ Public Support (SSI, SSDI, TANF, etc.) ☐ All Other Sources

STATE OF CALIFORNIA
HEALTH QUESTIONNAIRE
DR 218 (Rev. 07/12)

DEPARTMENT OF REHABILITATION

Date

Applicant's Name	Social Security Number	Insurance Coverage
	XXX - XX - XXXX	Medi-Cal# _____
Sex ☐ Male ☐ Female	Height / Weight	Medicare# _____
		Other: _____ # _____

I. APPLICATION REVIEW - Disability(ies) and functional limitation(s) reported on application: _____

II. REVIEW OF CURRENT HEALTH STATUS - Please explain any YES answer in COMMENTS section below.

BODY SYSTEMS - Are you now receiving or have you ever received medical treatment for:

	NO	YES	WHEN
1. Ear(s)/Hearing Problem			
2. Eye(s)/Visual Problem			
3. Mental/Emotional Problem			
4. Nervous Problem			
5. Lung/Respiratory Problem			
6. Heart/Circulation Problem			
7. Digestive Problem			
8. Kidney/Bladder Problem			
9. Legs/Feet/Arms/Hands Problem			
10. Back Problem			
11. Thyroid			
12. Diabetes			
13. Skin Problem			
14. High Blood Pressure			
15. Joint Problem			
16. Arthritis/Rheumatism			
17. Suppressed Immune System			
18. Other (Specify)			

FUNCTIONAL LIMITATIONS - Is your activity or ability to work currently limited by:

	NO	YES
19. Your Hearing		
20. Your Vision		
21. Your Ability to Learn/Read		
22. Your Ability to Speak		
23. Problem Breathing/Coughing		
24. Dizziness/Fainting		
25. Emotional Problems		
26. Weakness (State Where)		
27. Numbness (State Where)		
28. Pain (State Where)		
29. Your Memory		
30. Your Ability to Concentrate		
31. Spells of Unconsciousness		
32. Seizures		
33. Problem Balancing		
34. Problem Walking		
35. Problem Using Hands/Arms/Legs (Specify)		
36. Problem Lifting		
37. Problem Bending		
38. Problem Standing		
39. Problem Climbing		
40. Problem Crawling		
41. Problem Kneeling		
42. Problem Sitting		
43. Difficulty with Driving		
44. Other (Specify)		

COMMENTS:
Explain any YES answers in the space below.
Please indicate the specific item number to which you are referring, the specific problem(s)/area(s) affected, and, if undergoing treatment, the name and address of the provider, if other than listed in Sections E, F, or G on the reverse.
Attach additional sheets if necessary.

Heath Questionnaire (DR218)

Employment Record (DR222B)

STATE OF CALIFORNIA
EMPLOYMENT RECORD
DR 222B (Rev. 3-91)

DEPARTMENT OF REHABILITATION

INSTRUCTIONS: PLEASE COMPLETE ALL PAGES OF THIS FORM

Careful completion of all sections of this form will help us to determine your eligibility and assist in vocational planning. In addition to employment, include trade/vocational training, special licenses, and related information. This information will be kept confidential.

Applicant/Client's Name
Date

SECTION I EDUCATIONAL/VOCATIONAL TRAINING

Check Highest Grade Completed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

☐ GED College ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

TRADE, VOCATIONAL, OR PROFESSIONAL INSTITUTIONS OF HIGHER EDUCATION ATTENDED:

School	Major Courses	Certificate/Degree
School	Major Courses	Certificate/Degree

MILITARY WORK EXPERIENCE OR TRAINING:	FOREIGN LANGUAGES:

SECTION II WORK EXPERIENCE

List Last Employer First – Include Volunteer Experience

Employer			Date Began
Address: Street	City	State	Date Ended
Name of Job			Wages

Can you still do this type of work?
☐ Yes ☐ No If not, why not?

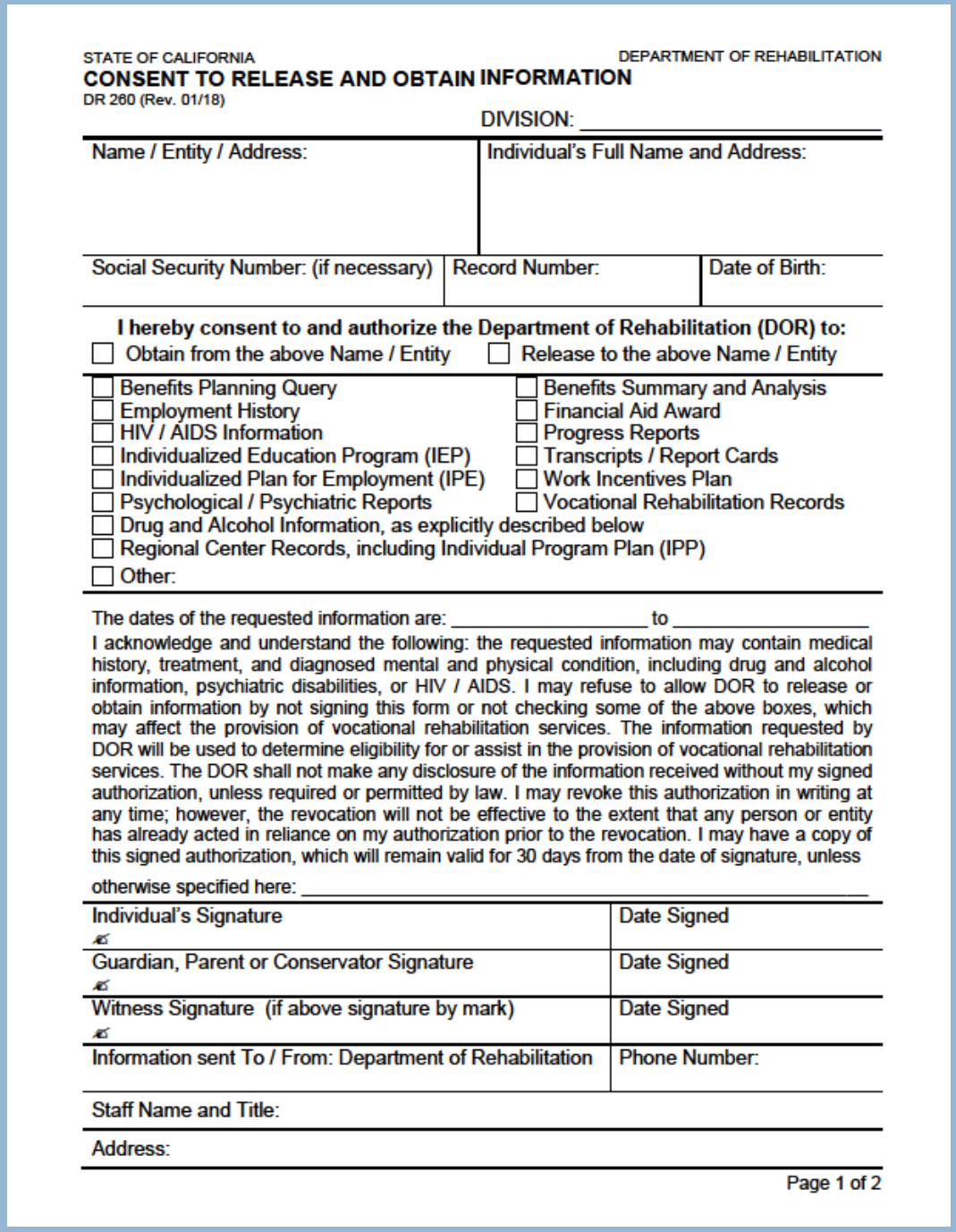
Your Duties: *(Describe exactly what you did. List tools and equipment used.)*

Reason for leaving

What about your work did you like?

What did you dislike?

Consent to Release and Obtain Information (DR260)



STATE OF CALIFORNIA — DEPARTMENT OF REHABILITATION

CONSENT TO RELEASE AND OBTAIN INFORMATION

DR 260 (Rev. 01/18)

DIVISION: _____

Name / Entity / Address:	Individual's Full Name and Address:

Social Security Number: (if necessary)	Record Number:	Date of Birth:

I hereby consent to and authorize the Department of Rehabilitation (DOR) to:

☐ Obtain from the above Name / Entity ☐ Release to the above Name / Entity

☐ Benefits Planning Query
☐ Employment History
☐ HIV / AIDS Information
☐ Individualized Education Program (IEP)
☐ Individualized Plan for Employment (IPE)
☐ Psychological / Psychiatric Reports
☐ Benefits Summary and Analysis
☐ Financial Aid Award
☐ Progress Reports
☐ Transcripts / Report Cards
☐ Work Incentives Plan
☐ Vocational Rehabilitation Records
☐ Drug and Alcohol Information, as explicitly described below
☐ Regional Center Records, including Individual Program Plan (IPP)
☐ Other:

The dates of the requested information are: _____ to _____

I acknowledge and understand the following: the requested information may contain medical history, treatment, and diagnosed mental and physical condition, including drug and alcohol information, psychiatric disabilities, or HIV / AIDS. I may refuse to allow DOR to release or obtain information by not signing this form or not checking some of the above boxes, which may affect the provision of vocational rehabilitation services. The information requested by DOR will be used to determine eligibility for or assist in the provision of vocational rehabilitation services. The DOR shall not make any disclosure of the information received without my signed authorization, unless required or permitted by law. I may revoke this authorization in writing at any time; however, the revocation will not be effective to the extent that any person or entity has already acted in reliance on my authorization prior to the revocation. I may have a copy of this signed authorization, which will remain valid for 30 days from the date of signature, unless otherwise specified here: _____

Individual's Signature ✍	Date Signed
Guardian, Parent or Conservator Signature ✍	Date Signed
Witness Signature (if above signature by mark) ✍	Date Signed
Information sent To / From: Department of Rehabilitation	Phone Number:

Staff Name and Title:

Address:

Page 1 of 2

CONTACT INFORMATION

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Questions & Answers