

## APPENDIX E FORMS AND INSTRUCTIONS

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**STATE OF ARKANSAS VOTER'S  
AGENCY-BASED DECLARATION STATEMENT**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

- YES, I want to apply to register to vote.
- NO, I do not want to apply to register to vote.

**If you do not check either box, you will be considered to have decided not to register to vote at this time.**

**Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.**

**If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.**

**If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at the State Capitol, Little Rock, AR 72201-1094 or call 1-800-482-1127 (TDD 1-800-262-4704).**

**If you decline to register to vote, the fact that you have declined to register will remain confidential and will be used only for voter registration purposes.**

**If you do register to vote, the office at which you submit a voter registration application will remain confidential and will be used only for voter registration purposes.**

**Comments:**

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



Secretary of State  
ATTN: Voter Registration  
P. O. Box 8111  
Little Rock, Arkansas 72203-8111

First  
Class  
Postage  
Required

-----  
-----  
-----

From:

### Deadline Information

To qualify to vote in the next election, you must apply to register to vote 30 days before the election. If you mail this form, it must be postmarked by that date. You may also present it to a voter registration agency representative by that date. If you miss the deadline you will not be registered in time to vote in that election.

If you are qualified and the information on your form is complete, you will be notified of your voting precinct by your local County Clerk.

### To Mail

Fold form on middle perforation, remove plastic strip, seal at bottom, stamp and mail.

Questions?  
Call your local County Clerk  
or  
Secretary of State's Office Voter Services  
1-800-482-1127  
TDD 1-800-262-4704

Contact your County Clerk if you have not received confirmation of this application within two weeks.



**Arkansas Secretary of State**  
 Voter Registration Site Monthly Reporting Form  
 Voter Registration  
 P.O. Box 8111  
 Little Rock, Arkansas 72203-8111  
**(Current Officer name) Secretary of State**

**Elections Division**  
 Voter Services  
 1-501-682-1686  
 1-800-247-3312

**Remember to put your AGENCY CODE on all Voter Registration Applications**

Please send completed APPLICATIONS to Secretary of State **DAILY**. Retain all Declination Forms for 24 months. Send original of this form to the Secretary of State.

**You must retain the yellow copy for your records for 24 Months.**

Agency: \_\_\_\_\_ Agency Code: \_\_\_\_\_ Month/Year: \_\_\_\_\_

Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

ZIP Code \_\_\_\_\_ County \_\_\_\_\_

Agency Contact \_\_\_\_\_ Telephone Number \_\_\_\_\_

WEEK 1	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
DATE								
Number of VR Applications								
Number of Declinations								

WEEK 2	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
DATE								
Number of VR Applications								
Number of Declinations								

WEEK 3	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
DATE								
Number of VR Applications								
Number of Declinations								

WEEK 4	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
DATES								
Number of VR Applications								
Number of Declinations								

WEEK 5	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
DATES								
Number of VR Applications								
Number of Declinations								

Rev. 1/1/11 New Application for Service Agency Grand Total Number of VR Applications Grand Total Declinations Grand Total

# VOTER REGISTRATION (3 FORMS) INSTRUCTIONS

## AGENCY BASED VOTER DECLARATION STATEMENT

*See the Secretary of State Website for current forms.*

## VOTER REGISTRATION APPLICATION

## VOTER REGISTRATION MONTHLY REPORTING FORM

State regulations require that ARS offer voter registration onsite to individuals who may not be currently registered to vote.

The counselor will complete the Agency-based Declaration Statement and have the individual sign.

If the individual desires to register to vote, the counselor will assist the individual in completing the Arkansas Voter Registration Application and will mail the completed form to the Secretary of State Office.

A designated person in each office will keep a record of all applications, declinations, and report to the Secretary of State Office monthly.

# ARKANSAS REHABILITATION SERVICES INFORMED CONSENT

Client Name \_\_\_\_\_  
(Last) (First) (MI) Social Security Number

Authorization is hereby granted for referral of the above named individual to the Arkansas Rehabilitation Services. As parent/guardian I understand that in order to determine eligibility and required services to achieve a vocational goal, a comprehensive evaluation may be required. My signature authorizes the Arkansas Rehabilitation Services to conduct such an evaluation including medical, mental health, psychological, and/or vocational assessments.

Authorization is also granted to \_\_\_\_\_  
(school, agency, clinic)

to release information in the record of the above named individual to the Arkansas Rehabilitation Services

(Counselor) \_\_\_\_\_

(Address) \_\_\_\_\_  
\_\_\_\_\_

Type of information to be disclosed:  Medical  
 Psychological  
 Vocational  
 Other (specify) \_\_\_\_\_

Purpose for such disclosure:  Establish eligibility  
 Develop VR plan  
 Determine treatment need/type  
 Other (specify) \_\_\_\_\_

I understand the purpose(s) for which my consent is being requested. I understand that giving consent for the above stated purpose(s) is voluntary on my part and may be revoked at any time.

\_\_\_\_\_  
Parent/Guardian Signature Date

# CONFLICT OF INTEREST DISCLOSURE FORM

## INTERNAL MEMORANDUM

TO: District Manager

FROM:

DATE:

SUBJECT: **Disclosure of Possible Conflict of Interest  
ARS Policy Section II**

This is to inform you I am aware \_\_\_\_\_ is a(n)  
(applicant/recipient/vendor) of services from our agency. \_\_\_\_\_  
is my (indicate if a relative, business or personal relationship.) I am required to notify  
you of this matter. Please advise how the services will be provided and/or monitored

District Managers Plan of Monitoring and Review:

Employee Signature \_\_\_\_\_  
Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_  
Date \_\_\_\_\_

### Demographic Information Form

**Current Name:**

Title:

Last Name:

First Name:

Middle Initial:

Suffix:

Salutation:

Use this Name?

Date of Birth:

Gender:

**Current Addresses:**

Facility:

Street:

Suite/Apt:

Zip:

City:

State:

County Cd.:

County:

Type:  
Mail Here?

Main Residence?

Archive?

Archived Date:

**Telecom:** Phone #  
Home:

Cell:

Work:

Text Only?

Alt Phone:

Video:

TDD ?   
E-mail:

Alt E-mail

**Transportation Information (Choose all that apply)**

- Do you have a valid driver's license?
- Do you own your vehicle?
- Do you have access to a vehicle other than your own?
- Can someone give you a ride?
- Do you use Public Transportation?
- Other?

**Communication**

Primary Language:

Other Languages:

Manual Communication Mode:

**Primary Counselor(s):**

**Client's Office:**

**Caseload Assignment**

Assigned to:

Start Date:

End Date:

Primary?

**Team Assignment**

Assigned to:

Start Date:

End Date:

Primary?

**Worker Assignment**

Assigned to:

Start Date:

End Date:

Primary?

Last Name:

First Name:

Title:

Show Extended Information

Referral Specifics

Individual being referred:

Social Security:

Who took this referral?

Worker's Compensation?

Are you Currently Receiving:

SSI for Aged?

SSI for Disabled?

SSDI?

Assistance Requested:

Self Referral?

Individual Making Referral:

Last Name:

First Name:

Title:

Reason for Referral:

What is your disability?

Are you Employed?

This individual is (I am) interested in services to assist: (Check as many as appropriate)

- with preparing for and/or finding a job.
- with maintaining a job.
- with transitioning from school to work.
- with performing independent living skills.
- with hearing.

Pre Application:

How does your disability interfere with your ability to work?

Why aren't you working now?

**Pg 2 Referral Specifics**

Are you ready to go to work now?

Have you been looking for employment on your own?

Explain:

**Other Agencies and Contact(s):**

Last Name:  First Name:

Title:

Contact Type:

Show Extended Information

**For Office Use Only:**

Target Group:

Referral Source:

Referral Received Date:

STATE OF ARKANSAS



Mike Beebe  
Governor

Bill Walker  
Director

<http://www.arsinfo.org>  
An Equal Opportunity Employer

Arkansas Career Education  
Division of Rehabilitation Services  
Randy Laverty, Commissioner

APPLICATION FOR SERVICES

NAME:

I understand that I am responsible to help the Arkansas Rehabilitation Services (ARS) to determine my eligibility within 60 days of my application. I will be an applicant when I have:

- Signed the bottom of this form,
- Completed a ARS Intake Questionnaire, and
- Helped ARS to begin to get information that is needed to decide if I am eligible for services.

I understand that all of the information that ARS gathers about me will be confidential. This information will not be released to anyone without my informed written consent, except where allowed or required by law. It may be released if my actions cause serious concern about my safety or the safety of others. When ARS receives the information about me ARS will review it to determine if I am eligible for vocational rehabilitation services.

I understand that ARS can only pay for services if ARS writes an authorization before the services begin. I will not make promises to others that ARS will pay for any goods or services.

ARS has given me information about the Client Assistance Program (CAP) that is available in Arkansas (**see reverse**).

My counselor has explained the Order of Selection policy to me.

I understand that ARS may get information about my Social Security or Department of Social Services benefits, as well as Department of Labor employment records, for purposes of my vocational rehabilitation program.

If I disagree with any decision made by ARS (see Consumer Handbook for more information):

- I should first speak with my counselor to try to work out the problem.
- I also have the right to request an Informal Review by the District Director, mediation and/or Administrative Hearing.
- I must make a request for these steps within 30 days after they have notified me of the decision I disagree with.
- If I want to request an Informal Review, I must send my request to the ARS District Director in my area.
- If I want to request mediation or an Administrative Hearing, I must send my request to the ARS Director, Department of Social Services

**I am applying for ARS services because I want to work, or to keep my job if I am employed.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Name of Counselor

\_\_\_\_\_  
Office

\_\_\_\_\_  
Telephone

## ARKANSAS REHABILITATION SERVICES

### WHEN YOU HAVE QUESTIONS:

If you do not understand what is happening with your application for services, or what is expected of you, or you have any other questions, first talk to your counselor. If this does not solve your concerns or answer your questions, you are then encouraged to speak to your counselor's supervisor and/or District Director.

You can find information about ARS services, the ARS eligibility process, and about what to do if you disagree with ARS in the ARS Consumer Handbook.

### ANOTHER SOURCE OF ASSISTANCE IS:

#### **CLIENT ASSISTANCE PROGRAM**

#### **WHAT IS THE CLIENT ASSISTANCE PROGRAM (CAP)?**

CAP is a program to help you to understand your rights under the vocational rehabilitation program or help you if you have problems receiving services from the Arkansas Rehabilitation Services. CAP can provide advice, representation, or legal assistance, if appropriate.

All services are free of charge and provided on a non-discriminatory basis.

**VR Intake**

Name:

Case#:

SSN:

Home Telephone:

Street:

Suite/Apt#:

City:

County:

Email:

Referral Received Date:

DOB:

Gender:

Zip:

State:

Referral Source:

Involvement with Other Agencies and Services at Application (Select up to 3)

Other Agencies and Services 1:

Other Agencies and Services 2:

Other Agencies and Services 3:

**Race/Ethnicity:**

- White?
- Black or African American?
- American Indian or Alaska Native?
- Asian?
- Native Hawaiian or Pacific Islander?
- Hispanic or Latino?

**Impairments**

Primary Impairment:

Cause of Primary Impairment:

Other Impairment:

Cause of Other Impairment:

Current or highest grade of school completed

Student with Disability in Secondary Education at Application

Living Arrangement

**Employment at Application:**

Is Client Working?

Work Status:

**Federal Reported Information**

Work Status:

Pay Period:

Amount:

Hours per week:

# of Jobs:

Days per week:

Earned:

**Medical Insurance Coverage at Application:**

- Any Medical Insurance at Application?
- Medicaid?
- Medicare?
- Public Insurance from Other Sources?
- Private Medical Insurance through Own Employment?
- Private Medical Insurance through Other Means?

**Other Income Source at Application:**

Please Enter Monthly Amount

**AMOUNT**

- SSI Aged
- SSI for the Disabled
- Temporary Assistance for Needy Families (TANF)
- General Assistance (State or Local Government) NOT FEDERAL
- Social Security Disability Insurance (SSDI)
- Veteran's Disability Benefits
- Worker's Compensation
- Family and/or Friends
- Other Public Assistance
- Free or Reduced Lunch Program

Primary Source of Support at Application:

**Primary Counselor(s):**

**Client's Office:**

**Caseload Assignment**

Assigned to:

Start Date:

End Date:

Primary?

**Team Assignment**

Assigned to:

Start Date:

End Date:

Primary?

**Worker Assignment**

Assigned to:

Start Date:

End Date:

Primary?

Resends Assignments

**Special Categories (Y=Yes N=No):**

Honorably Discharged Veteran?

Projects with Industry?

Has the Client ever received services under an Individualized Education Program?

Eligible to Work in the USA?  Help

Previous Criminal History?

Special Project:

**Communication:**

Primary Language:

Other Languages:

Manual Communication Mode:

Have you received a Ticket to Work from Social Security?

### Work History Form

Last Name:  First Name:  MI:

Date of Birth:

Counselor:

#### Employment Information

---

Primary?

Occupation:

Job Title:

Department:

Start Date:  End Date:

Work Status:

Employer's Name:

Employer's Address:

Pay Period:

Amount:

Hours per week:

Days Per Week:

Hourly wage

Weekly Wage

Annual Wage

Is this wage comparable with other people for the same job with the same employer?

Medical Benefits (including waiting time, if any):

Physical, cognitive and social demands:

Accommodations, Supports or Specialized Strategies:

Duties and Skills:

Job Modifications:

Reason For Leaving:

Comments:

Contact employer?

Show Contacts

If Used:

CRP Vendor:

ACTI:

Type of ACTI services provided:

Complete?

Primary?

Occupation

Job Title:

Department:

Start Date:

End Date:

Work Status:

Employer's Name:

Employer's Address:

**Pg 3 Work History**

Pay Period:

Amount:

Hours per week:

Days Per Week:

Hourly wage

Weekly Wage

Annual Wage

Is this wage comparable with other people for the same job with the same employer?

Medical Benefits (including waiting time, if any):

Physical, cognitive and social demands:

Accommodations, Supports or Specialized Strategies:

Duties and Skills:

Job Modifications:

Reasons For Leaving:

Comments:

Contact employers?

Show Contacts

If Used:

CRP Vendor:

ACTI:

Type of ACTI services provided:

Complete?

**Current Benefits**

Health Insurance

Paid Leave

Paid Life Insurance

Employer Pays All Medical

### Educational History

Client:

Current/highest grade of school completed:

Currently/previously in a special education program?

Special Education Services Received:

Home Schooled?

GED attained?

### Elementary and Secondary Education (Only Most Recent Required)

Dates attended:  through

School's Name:

School Address:

Services Provided By School:

Contacts At This School:

Last Name:  First Name:

Title:

+Show Extended Information

### College and Vocational Education

Dates attended:  through

School's Name:

School Address:

Major/Field of Study:

Certification/Degree:

Date Obtained:

Vocational Training:

Other Training (e.g. military, correspondence courses, on-the-job, etc.):

**Pg 2 Education History**

Other Certifications:

**Other Skills By Self Report**

- Computer Skills?
- Typing?
- Foreign Languages?
- Adaptive Tech?
- Other Skills:

Other Skills:

## CASE NOTE/NARRATIVE

### Client Contact Note

Client Name:

Date:

Description:

Whose Note:

For Program:

Status:

Type of Contact:

Flag this Contact Note?

Note:

Assign this as a task to:

---

### CASE NOTE/NARRATIVE INSTRUCTIONS

Specific documentation in the case record/ECF is required during the vocational rehabilitation process.

The case note/narrative form is used for the documentation of status movement, headings for referral and acceptance/plan development.



State of Arkansas  
 Department of Career Education  
**AUTHORIZATION FOR  
 DISCLOSURE OF INFORMATION**

This form must be signed in order for the Department of Career Education (ACE) to disclose information (including information about your health condition or treatment or payment for a health condition that ACE has in its records, also known as protected health information ("PHI"), if the use or disclosure is not directly related to running ACE's programs or required by law or court order.

**Subject of this Authorization (name of ACE Client)**

**I authorize ACE to disclose the information indicated below to: (name and address)**

Street:

Suite/Apt:

City:

Zip:

State:

or the following purpose(s):

*(If you do not wish to state a purpose, you can write "at my request")*

Type of Information ACE is Authorized to Disclose (check those that apply)

- medical\*
- alcohol and/or drug treatment record\*\*
- HIV related Information\*\*\*
- financial
- employment history
- family and living situation
- ACE and other benefits currently or formerly received;
- records maintained by the Division of Rehabilitation Services (ARS)
- other

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from ACE.
- I understand that I may revoke this authorization by notifying ACE, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by regulations.

This authorization expires on \_\_\_\_\_ (date) or upon \_\_\_\_\_ (event). *(If use or disclosure of PHI is for research purposes, including the creation and maintenance of a database, you can write "end of research study" or "none".)*

\_\_\_\_\_  
 Signature of individual or Representative

\_\_\_\_\_  
 ID# or S.S.# of Subject

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Person Who Signed

\_\_\_\_\_  
 If a Representative, Authority to Act

**Note to Recipient of Information:**

- The confidentiality of psychiatric records is required under chapter 899 of the Arkansas general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

## Pg 2 Authorization for Disclosure Information

\*\* **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by the Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise, permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

\*\*\* **HIV Related Information:** This information has been disclosed to you from records whose confidentiality protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by the state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

THIS INFORMATION IS AVAILABLE IN ALERNATE FORMATS. PHONE (800) 842-4524



Mike Beebe  
Governor

Bill Walker  
Director

<http://www.arsinfo.org>  
An Equal Opportunity Employer

**Arkansas Career Education  
Division of Rehabilitation  
Services**  
Randy Laverty , Commissioner

**RIDAC Service Authorization**

**Client Information**

SSN:   
Last Name:  First Name:  MI:   
Date of Contact

**Current Addresses:**

Facility:   
Street:   
Suite/Apt:  Zip:   
City:  State:   
County Cd.:   
County:   
Type:   
Mail Here?  Main Residence?   
Archive?  Archived Date:

**Telecom:**

Home:   
Cell:  Text Only?   
TDD?   
E-mail:

**Purpose of Evaluation**

Center Counselor:   
Field Counselor:   
Evaluator:   
Date Entered Work Performance:   
Staffing Date:   
Date of Birth:

**Impairments**

Primary Impairment:

Cause of Primary Impairment:

Other Impairment:

Cause of Other Impairment:

**Evaluation**

[@ Service Name Label]

Service Detail

[@ Service Name Label]

Service Detail

[@ Service Name Label]

Service Detail

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

**ARKANSAS REHABILITATION SERVICES  
GENERAL MEDICAL ASSESSMENT**

\_\_\_\_\_  
Counselor Name                      Counselor#                      Location

***To Be Completed by Counselor***

Client's Name

Birth Date

Primary Physician

Location

**CLIENT DESCRIPTION OF DISABILITY:**

**COUNSELOR OBSERVATIONS:**

**TO BE COMPLETED BY PHYSICIAN (FRONT AND BACK)**

**PRIMARY DISABLING CONDITON:**

**CHARACTERISTICS OF DISABLING CONDITION (Check as indicated)**

Permanent  Temporary  Stable  Improving   
 Slowly Progressive  Rapidly Progressive

**MAJOR DISABLING CONDITION CAN BE:**

Removed by treatment: Yes  No

Substantially reduced by treatment: Yes  No

**SECONDARY (AND OTHER) DISABLING CONDITION:**

**Physical Activities:**

**Limitations**                      **To be Avoided**

Walking	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>

**Working Conditions:**

**Limitations**                      **To be Avoided**

Outside	<input type="checkbox"/>	<input type="checkbox"/>
Inside	<input type="checkbox"/>	<input type="checkbox"/>
Humid	<input type="checkbox"/>	<input type="checkbox"/>
Dry	<input type="checkbox"/>	<input type="checkbox"/>
Dusty	<input type="checkbox"/>	<input type="checkbox"/>
Temperature Extremes	<input type="checkbox"/>	<input type="checkbox"/>
Dangerous Machinery	<input type="checkbox"/>	<input type="checkbox"/>
Heights	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Vapors	<input type="checkbox"/>	<input type="checkbox"/>
Loud Noises	<input type="checkbox"/>	<input type="checkbox"/>

**OTHER:**

**RECOMMENDATIONS: (Indicate as Appropriate)**

**SPECIALIST EXAMINATION ADVISABLE FOR COMPLETENESS OF DIAGNOSIS OR PROGNOSIS (SPECIFY TYPE)**

**TREATMENT (SPECIFY TYPE AND APPROXIMATE DURATION) OTHER**

**REMARKS:**

**HISTORY AND PHYSICAL**

**PROBLEM INDICATED**

**DESCRIPTION OF PROBLEM**

**HEENT**      No     Yes

**HEARING**    No     Yes

**LUNGS**      No     Yes

**HEART**      No     Yes

**ORTHOPEDIC**    No     Yes

**NEUROLOGICAL/MENTAL STATUS** No  Yes

**OTHER**

**PHYSICIAN SIGNATURE:**

**DATE:**

**CLIENT'S NAME:**

**GENERAL MEDICAL ASSESSMENT  
AND  
(NEXT TWO FORMS)  
MEDICAL CONSULTANT WORKSHEET  
PHYSICIAN CONSULTANT WORKSHEET INSTRUCTIONS**

The counselor will complete the top section of the form. The Physician completes the form.

CLIENT:  DATE:

Counselor:  Counselor#:  Location:

Vocational Objective:

	Yes	No	Recommendation	Date of re-evaluation
<b>I. Diagnosis</b>				
A. Is general physical examination adequate?				
B. Do signs suggest further study?				
1. Are further tests indicated?				
a. Laboratory tests				
b. X-ray				
2. Is specialist consultation indicated?				
3. Is hospitalization for diagnosis indicated?				
<b>II Prognosis</b>				
A. Is disability "static"?				
B. Can major disability be removed or substantially reduced by treatment in a reasonable length of time?				
<b>III. Rehabilitation Plan</b>				
A. Is treatment plan satisfactory?				
B. In Training plan satisfactory from a physical standpoint?				
C. Is Placement plan satisfactory from a physical standpoint?				

**Comments:**

**M.D.**

**Client:**

**Pg 2 Physician Consultant Worksheet**

Client name:

Age:

Counselor:

Office:

Identified Medical Condition(s):

Characteristics of Medical Condition(s):

Permanent    Temporary    Stable    Improving

Medical Condition(s) can be:

Removed by Treatment: Yes  No

Substantially Reduced by Treatment: Yes  No

**Vocational Limitations:**

**Physical Activities:**  
**Limitations**

**To be Avoided**

Walking	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>

**Working Conditions:**  
**Limitations**

**To be Avoided**

Outside	<input type="checkbox"/>	<input type="checkbox"/>
Inside	<input type="checkbox"/>	<input type="checkbox"/>
Humid	<input type="checkbox"/>	<input type="checkbox"/>
Dry	<input type="checkbox"/>	<input type="checkbox"/>
Dusty	<input type="checkbox"/>	<input type="checkbox"/>
Temperature Extremes	<input type="checkbox"/>	<input type="checkbox"/>
Dangerous Machinery	<input type="checkbox"/>	<input type="checkbox"/>
Heights	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Vapors	<input type="checkbox"/>	<input type="checkbox"/>
Loud Noises	<input type="checkbox"/>	<input type="checkbox"/>

**Other:**

**Recommendations/Conclusion:**

**Physician's Signature:**

**M.D./Date:**

**Client Name:**

## **GASTRIC BYPASS STATEMENT OF UNDERSTANDING**

I understand that weight reduction surgery is a complicated medical procedure and there are risks involved. As part of my rehabilitation program, I agree to adhere to the recommendations of the surgeon and any other treating physicians or medical professionals at the time of surgery and during my recovery process. I understand that weight reduction surgery is not a “magic cure” but only an initial step in my effort to lose weight due to morbid obesity. I understand I must commit to a change in my lifestyle in order to lost weight and maintain a weight that does not pose a threat to my health. I agree to adhere to medically recommended diet and exercise programs and understand that if I do not adhere to such programs, I can regain a significant portion of any weight I may have lost as a result of the surgery. I have been informed of the research that indicates 5 years post-surgery 70% of individuals who have weight reduction surgery regain 50% of weight initially lost. I have been informed that due to the above-mentioned research it is the practice of Arkansas Rehabilitation Services to pay for the weight reduction surgery one time.

I understand this service is provided to help me to gain or maintain employment.

---

Client Signature

Date

## GASTRIC BYPASS SURGERY CHECKLIST

Required information for submission to the District Manager

Client's Name: \_\_\_\_\_

	Yes	No
General Medical Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Documentation of morbid obesity at least 5 years	<input type="checkbox"/>	<input type="checkbox"/>
BMI 55 or Greater	<input type="checkbox"/>	<input type="checkbox"/>
<b>Co-Morbid Conditions:</b>		
Uncontrolled Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Uncontrolled Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Hypoventilation	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Failure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Low Back, Legs, Feet)	<input type="checkbox"/>	<input type="checkbox"/>
Reflux Esophagitis	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Documentation from treating physician of success or failure in a Structured weight loss program for 1 year while under his/her care	<input type="checkbox"/>	<input type="checkbox"/>
Examination by a surgeon proficient in bariatric surgery With recommendation for surgery	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Signed Local Medical Consultant Worksheet	<input type="checkbox"/>	<input type="checkbox"/>
Signed memorandum of understanding by the client	<input type="checkbox"/>	<input type="checkbox"/>
Has realistic expectations	<input type="checkbox"/>	<input type="checkbox"/>
Understands & agrees to long term follow-up	<input type="checkbox"/>	<input type="checkbox"/>
Understands postoperative restrictions	<input type="checkbox"/>	<input type="checkbox"/>
Documentation of eligibility and order of selection criteria	<input type="checkbox"/>	<input type="checkbox"/>
Signed memorandum of understanding by the client	<input type="checkbox"/>	<input type="checkbox"/>
Case narrative documentation of counseling issues	<input type="checkbox"/>	<input type="checkbox"/>
Approval of District Manager	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

**Arkansas Department of Career Education**  
**Arkansas Rehabilitation Services**  
**525 W. Capitol**  
**Little Rock, AR 72205 1**  
**Phone/TTY (501) 683-0719 or Toll Free/TTY 800-828-2799 or fax (501) 666-5319**

**Date:**

**To: AT @ Work Team Fax 501-686-2831**

**Counselor:**  **Client:**

**Address:**  **Address:**

**City:**  **Zip:**  **City:**  **Zip:**

**Email:**  **Phone:**

**Phone:**  **Cell/Work:**

**Fax:**

**Disability(s):**

**Client is:** ( ) Vocational Rehabilitation      ( ) Independent Living

**Reason for Referral:**

**Note: Referral Form is the only information required. AT @ Work evaluator will contact referring Counselor if additional information is needed.**

# **ASSISTIVE TECHNOLOGY @ WORK INSTRUCTIONS**

## **REFERRAL AND ASSESSMENT PROCESS**

The AT @ Work program (Assistive Technology at Work) is designed to assist the ARS consumer and the referring Counselor in selecting and obtaining the appropriate assistive technology. The program is a collaborative effort involving Little Rock based staff as well as ACTI therapy staff. Services offered include evaluation/assessment, assistive technology device training, device modification/adaptation, and technical assistance as it relates to work, school, home, and transportation. ARS Counselors are required to determine the need for assistive technology at the time of application, plan development, and placement.

The following process is recommended in those situations when the Counselor identifies the potential need for assistive technology:

- 1) Counselor determines need for an assistive technology assessment or consultation.
- 2) Counselor completes the AT @ Work Referral Form in full and forwards to the AT @ Work Program Manager via e-mail or fax.
- 3) Program Manager receives Referral Form, reviews and assigns to the appropriate AT @ Work evaluator. (If referral requests a wheelchair or orthotic/prosthetic assessment referral is forwarded to the physical therapy department at ACTI. The physical therapist will contact the referring Counselor to discuss the need for the consumer referred to visit the ACTI.)
- 4) Evaluator reviews the referral. Prior to scheduling the assessment, the Evaluator contacts the referring Counselor to ascertain the Counselor's perception of the individual's specific needs and requests other information.
- 5) Evaluator and Counselor will discuss the availability of IL or VR funds and determine the need to proceed with the evaluation.
- 6) Evaluator and Counselor will determine responsibility of scheduling the assessment in a timely manner based on the availability of the consumer, Counselor and evaluator.
- 7) Evaluator will complete a functional assessment addressing the referred individual's specific need of assistive technology based on the Counselor's request.
- 8) Evaluator will complete a report summarizing findings with recommendations for any needed technology prioritized.
- 9) Evaluator and Counselor will determine responsibility for procurement of recommended and agreed upon assistive technology. The Evaluator will provide vendor information, along with the quoted cost of the technology.
- 10) Evaluator will determine training needs regarding recommended technology prior to purchase.
- 11) Evaluator and Counselor will jointly agree as to responsibility for follow-up services including final approval of modifications/adaptations.
- 12) The Counselor will be responsible for processing payment of authorized and purchased technology.

### Certificate of Eligibility/Ineligibility

Name:

**Confirmed Impairments**

Primary Impairment:

Cause of Primary Impairment:

Other Impairment:

Cause of Other Impairment:

Presumptively Eligible? \_\_\_\_\_

**Eligibility Justification:**

Describe visual impairment(s) and other physical or mental impairments, if any. List documentation which substantiates the impairment(s).

List functional limitations and other factors specific to the vision loss, other impairments, or the combination of vision loss and other impairments.

- Communication
  - Limitations:

- Interpersonal Skills
  - Limitations

- Mobility Skills

- Limitations

- Self Care

- Limitations

- Self Direction

- Limitations

- Work Skills

- Limitations

Explain how these limitations cause a substantial impediment to employment for the individual:

Describe why VR services are required for the individual to prepare for, enter, engage in, or retain gainful employment

Priority:  Order of Selection:

Significantly Disabled?

Unable to determine client eligibility at this time. Client will be placed in Extended Evaluation (status 06) until adequate information is available.

Date of Extended Evaluation:

Open EE Plan

Extended Evaluation Over on:

Date of Trial Work Plan:

Open TW Plan

Trial Work Plan Over On:

Individual has been determined to be Eligible for vocational rehabilitation services to prepare for, secure, retain, or regain employment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## **CERTIFICATE OF ELIGIBILITY INSTRUCTIONS**

1. The Certificate of Eligibility is generated by the case management system after Status 10 is keyed.
2. The Certificate of Eligibility form is displayed with the individual's name, Social Security Number, and counselor's name.
3. The physical or mental disability, the limitations, and the date of certification are to be keyed.
4. Check appropriate box for Trial Work Experience, Extended Evaluation, or VR services.
5. The Certificate of Eligibility for Trial Work Experience, EE, or VR services is not valid if not signed by the counselor and the Date of Certification entered.
6. The Certificate of Eligibility is attached to the ECF.

## **CERTIFICATE OF INELIGIBILITY INSTRUCTIONS**

1. The Certificate of Ineligibility will be completed when the case is closed "08" from Status 02.
2. The Certificate of Ineligibility generated by the case management system after Status 08 is keyed.
3. The Certificate of Ineligibility form is displayed with the individual's name, Social Security Number, and counselor's name.
4. In the space provided, explain the reason the individual is ineligible for services.
5. Describe in the space provided the client's participation in the decision reached.
6. Record the date scheduled for the annual review for all individuals closed from Status 02 found ineligible because the individual indicates the severity of disability prevents participation in a rehabilitation program.
7. The electronic date and signatures of the individual and counselor indicate understanding of, and agreement.
8. When an individual is closed in Status "08" from Status 02, a Certificate is completed, provide a copy to the applicant and a copy is attached to the ECF.

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Director

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Randy Laverty , Commissioner

ILRS Certificate of Eligibility/Ineligibility

Name:  Case Number:   
Counselor:  Signed Date:

- The limitation from the impairment constitutes a substantial impediment to independent living.
- This disability constitutes or results in a substantial limitation to the independent living and/or employment.
- There is a reasonable expectation that independent living services may significantly assist the individual to improve his/her ability to function independently in family or community independent functioning.

The individual is certified Eligible for independent living services.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

## **CERTIFICATE OF ILRS ELIGIBILITY/INELIGIBILITY INSTRUCTIONS**

1. The Certificate of Eligibility for ILRS is generated by the case management system after Status 72 is keyed. The Certificate of Ineligibility for ILRS is generated by the case management system after appropriate Status is keyed.
2. The Certificate of Eligibility form for ILRS is displayed with the individual's name, Social Security Number, and counselor's name.
3. The Certificate of Eligibility is not valid if not signed by the counselor and the Date of Certification entered.
4. The Certificate of Eligibility must be attached to the ECF.
5. The physical or mental disability, the limitations, and the date of certification are to be keyed.
6. The electronic date and signatures of the individual and counselor indicate understanding of, and agreement.

# ARKANSAS REHABILITATION SERVICES

## ASSESSMENT FOR DETERMINING PRIORITY CATEGORY FOR SERVICES

NAME: \_\_\_\_\_ SSN \_\_\_\_\_  
           (LAST)                    (FIRST)                    (MI)

1. This individual has one or more impairments that are considered significant:  
    Yes   No
  
2. As a result of these impairments, the individual is significantly limited from maintaining or achieving employment due to chronic loss in the following capacity areas (as described and defined):

### MOBILITY

- Regularly requires any of the following to get around in the community:  
     Modifications, adaptive technology, accommodations, and assistance from others
- Range of travel is severely limited
- Unable to use upper and/or lower extremities
- Unable to control and coordinate fine and/or gross motor movements such as button buttons, wind watch, etc.

### SELF DIRECTION

- Requires supervision on a frequent or ongoing basis to begin and carry through with goals and plans, perform job tasks, monitor own behavior or make decisions
- Highly distractible/short attention span/severe difficulty concentrating on work
- Difficulty shifting focus from one task to the next
- Unable to work independently
- Unable to provide informed consent for life issues without assistance of a court appointed legal representative or guardian
- Unaware of consequences of behavior

### SELF CARE

- Requires assistance on the job for personal needs
- Places self and/or others at risk due to poor decision-making/reasoning, or judgment
- Requires extra attention or monitoring to prevent accident or injury
- Unable to perform normal activities of daily living without assistance such as hygiene, cooking, shopping and money management

### INTERPERSONAL SKILLS

- Has not acquired cultural or age appropriate social skills, which will impede employer/co-worker interaction
- Work history includes recent negative references, firings, multiple short-term jobs or other evidence of work adjustment problems
- Social isolation, withdrawal, or rejection by co-workers
- Frequent conflict with co-workers or supervisors
- Has significant difficulty interpreting and responding to behavior and communication of others

**ASSESSMENT FOR DETERMINING PRIORITY CATEGORY FOR SERVICES  
(continued)**

**COMMUNICATION**

- Unable to participate in conversation without accommodation or assistive technology (Video/visual, language board, interpreter, TTY, written aids, real-time captioning, etc.)
- Unable to understand telephone conversation even with amplification, including tactile or visually enhanced sign systems
- Expressive and receptive primary mode of communication is unintelligible to non-family members or general public
- Below the 5<sup>th</sup> grade level in reading or written expression
- Unable to access printed/visual information without assistive technology and/or accommodation

**WORK TOLERANCE**

- Requires frequent or extended periods of time from work due to necessary treatments or medical problems.
- Unable to climb a flight of stairs or walk 100 yards on level surface without pause
- Unable to lift 20 pounds (occasionally) or carry more than 10 pounds (frequently)
- Requires modification, adaptive technology and/or accommodations not typically required for others in terms of capacity or endurance (i.e. extra work periods, shorter workday or week, adjustments in starting and quitting times)
- Unable to sit/stand for more than two hours
- Unable to perform tasks at a competitive work pace

**WORK SKILLS**

- Unable to obtain or maintain employment usually available to persons of equivalent age and education
- Have few general skills, which could be readily used in a job, existing in the economy and/or job specific skills are largely unusable due to disability or other factors.
- Can only learn tasks that are routine or repetitive
- Requires accommodation or rehabilitation technology to participate in training to develop work skills
- Requires more training and supervision than other trainees to obtain/maintain job skills

**Are multiple services over an extended period of time expected:**       Yes     No

**Category**

**This individual meets the criteria for Priority for Services:**

I    II    III

Status 10

Status 04

(Please check appropriate box)

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date of Signature

## ORDER OF SELECTION-PRIORITY CATEGORY INSTRUCTIONS

When applicable ARS Order of Selection follows the procedures outlined.

1. Eligibility (Status 10) must be established prior to applying the Order of Selection.
2. Complete the Assessment for Determining Priority Category for Services.  
(See Appendix E)
3. The consumer will be notified in writing of the priority category using the required form letter. The original will be mailed to the individual and a copy will be placed in the ECF case file. (See Appendix E)
4. If under Order of Selection, Document the Category placement in the case note narrative by using the Order of Selection heading.
5. If the individual does not meet the level of the priority category necessary to receive services, the individual may choose to be placed in a waiting (list) Status 04, or be referred to other Workforce partners or agencies, or closed in Status 30.

STATE OF ARKANSAS



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Bill Walker  
Director

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Division of Rehabilitation Services  
Randy Laverty , Commissioner

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Dear

When you applied for Rehabilitation Services, I explained Order of Selection. This means that individuals who are most significantly disabled will receive priority for paid-for services. Based upon medical information obtained and a review of your rehabilitation potential, you are eligible and are being placed in:

- Category I (Most Significantly Disabled)
- Category II (Significantly Disabled)
- Category III (Non- Significantly Disabled)

If you are listed in Category I or II, contact me immediately to plan your Rehabilitation Program

If you are listed in Category III, you must choose to (check one):

- Assistance with referral to other workforce investment programs/benefits
- Be placed on a deferred services list until more funds are available
- Request that your case be closed

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

You should contact me immediately of your decision or if you do not understand this letter.

If you are not satisfied with your category placement, you may request an administrative review. Your request must be in writing within 30 days of the date of this letter to:

Sincerely,

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

## RS-16 Financial Resources

**Current Name:**Title: Last Name: First Name: Middle Initial: Suffix: Salutation: Use this Name? Total Number in Household: **I. CAPITAL ASSETS**

	Amount
1. Liquid Assets (Exempt single \$6,000; person with dependents \$12,000)	
2. Other	
3. TOTAL	

**II. MONTHLY INCOME**

	Amount
4. Salary (Continuing - Client Only)	
5. Retirement/Pension (Client Only)	
6. VA Disability (Client Only)	
7. SSDI (Client Only)	
8. SSI (Client Only)	
9. Annuities (Client Only)	
10. Private Insurance (Client Only)	
11. TANF (Client Only)	
12. Other (Include Family Income)	
13. TOTAL (Lines 4-12)	

**III. NORMAL LIVING REQUIREMENTS (do not complete for SSI/SSDI Recipients)**

	Amount
14. Family Group (See NLR Chart)	
15. Special Conditions	
16. Special Conditions	
17. TOTAL (Lines 14-16)	

**IV. CLIENT'S AVAILABLE RESOURCES (do not complete for SSI/SSDI Recipients)**

	Amount
18. Monthly Income Available (If Line 17 is greater than Line 13, enter 0).	
19. Income Available (Line 18 times months)	
20. Capital Assets (Line 3)	
21. TOTAL (Lines 19 & 20)	

**V. COMPARABLE BENEFITS**

	Yes/No	Amount
22. Medicaid		
23. Medicare		
24. Pell Grant		
25. Insurance		
26. VA (Educ/Tmg. Only)		
27. Worker's Compensation		
28. Other (Specify)		
29. TOTAL (Lines 22-28)		

Comments:

I hereby certify that all information in Section I through V is true to the best of my knowledge. I also grant permission for the Arkansas Rehabilitation Services to investigate the accuracy of this report. If my financial condition changes, I agree to notify the Counselor.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

## RS -16 FINANCIAL RESOURCES INSTRUCTIONS

The RS-16 is used to document financial resources and comparable benefits of the individual. The RS-16 must be included in the ECF of each individual prior to the provision of any services. **Individuals receiving SSI/SSDI are exempt from financial need assessment, but the comparable benefit section of the form should be completed to assess other available funding sources.** The IPE and IPE Amendments are used to summarize and compute the amount of supplementation. Instructions for completion of the RS-16 are to be followed to assure compliance with State policies and regulations.

If the individual is 23 years of age or under and unmarried, the parent(s) assets must be verified with a copy of the parent(s) income tax forms. If the parent(s) do not support the individual, the individual must provide documentation of non-support.

**Complete all sections of the financial resources in the electronic case management system.**

**Exception:** If the client's family states the client will not be claimed on next year's income tax, the client will no longer be considered a dependent. The client will be required to verify their source(s) of income to cover their expenses.

- Record the individual's name, date, and the total number in household.

### CAPITAL ASSETS

**1. Liquid Assets:** Liquid assets of the individual and spouse are cash on hand, saving and checking accounts, bonds, securities, and other negotiable papers that can readily be turned into cash. Deduct the first \$6,000 for persons (without dependent children), or \$12,000 for persons with dependent children and enter the remainder of liquid assets on the blank line. If none, enter 0. If the individual is 23 years of age or under and unmarried, the parent(s) assets must be included. A copy of the parent(s) income tax forms must be provided for this purpose. If the parent(s) do not support the individual, the individual must provide documentation of non-support.

**2. Other:** Enter any other capital assets.

**3. Total:** Enter the sum of the amounts in Lines 1-2. If none, enter 0.

### MONTHLY INCOME

Reported income must be verified. (See manual Section V)

If the individual or parent(s) reports zero income or did not file income tax forms, the individual must sign a written statement of verification. If the individual is 23 years of age or under and unmarried, the parent(s) income must be included. A copy of the parent(s) income tax forms must be provided for this purpose. If the parent(s) do not support the individual, the individual must provide documentation of non-support.

**4. Net Salary:** Deduct 25% of the gross income from the most recent paycheck computed on a monthly basis for a regular full-time employee.

Deduct 25% of the adjusted gross income computed on a monthly basis if the information is obtained from income tax returns or the PELL grant summary.

For farmers, teachers, or part-time employees, the amount entered will be the monthly average for the past 12 months. If income has ceased at the time of application or will not be continuing, enter 0 in the amount column.

**5. Retirement/Pension:** Enter the amount.

**6. VA Disability (Client Only):** Enter the amount.

**7. SSDI (Client Only):** Enter the amount.

**8. SSI (Client Only):** Enter the amount.

**9. Annuities (Client Only):** Enter the amount.

**10. Private Insurance (Client Only):** Enter the amount.

**11. TANF (Client Only):** Enter the amount.

**12. Other (Client Only)** Enter the source and the amount of any other income such as contributions, rent, board, etc. received. Enter the family income from parent(s) or spouse. If the individual is 23 years of age or under and unmarried, parent(s) income must be included.

**13. Total (Lines 4 – 12)** Enter the sum of amounts in Lines 4-12. If none, enter 0.

**NORMAL LIVING REQUIREMENTS (NLR)  
DO NOT COMPLETE FOR SSI/SSDI RECIPIENTS.**

**14. Family Group:** Enter from the Normal Living Requirements Table the amount in accordance with the household group and any modification. NLR includes shelter, food, clothing, general health maintenance, utilities, and basic standard living requirements.

<b>Number of Persons</b>	<b>Monthly Amount</b>
1	\$3,200.00
2	\$3,600.00
3	\$4,000.00
(\$400.00 for each additional family member)	

**15 & 16. Special Conditions:** Special Circumstances (conditions) of other expenditures/debts that impose unusual burdens on the client or family's income can be added to the normal living requirement. (Example: medication or medical payments for client or other family members, child support, education expenses, etc.) List and identify each special condition.

**17. Total:** Enter the sum of Lines 14 through 16.

**CLIENT'S AVAILABLE RESOURCES - DO NOT COMPLETE FOR SSI/SSDI RECIPIENTS.**

Each individual is expected to use all resources available for the rehabilitation program.

**18. Monthly Income Available** Line 17 minus Line 13. (If line 17 is greater than line 13 enter 0.)

**19. Income Available (Line 18 times Number of Months):** This amount represents continuing income available to the client. In all instances, any amount exceeding the NLR will be entered and used.

**20. Capital Assets:** Enter the amount from Line 3. If none, enter 0.

**21. Total:** Enter the sum of Lines 19 and 20.

**COMPARABLE BENEFITS - ESTIMATE IF EXACT AMOUNT IS NOT AVAILABLE.**

The comparable benefits provision provides VR agencies with an organized method for assessing an individual's eligibility for benefits under other programs. Any benefit available to individuals under any other program to meet, in whole or in part, the cost of any VR service will be utilized. This benefit will be considered only to the extent that it is available and timely.

A "comparable benefit" is not the same as "determination of economic need." In determination of economic need, the objective is to set the conditions for equitably determining the amount, if any, an individual is expected to participate in the cost of the rehabilitation. In the area of comparable benefits, the objective is to give full consideration to alternative funding sources prior to spending VR funds to purchase consumer services.

**22. Medicaid:** Check yes or no and enter the amount. If "no", enter 0.

**23. Medicare:** Check yes or no and enter the amount. If "no", enter 0.

**24. Pell Grant:** Check yes or no and enter the amount of grant as determined by the Financial Aid Administrator in the institution. If "no", enter 0.

**25. Insurance:** Check yes or no and enter the amount of insurance benefits available as determined by client statement or review of policy. The name of the company and policy number will be entered, if known. If "no", enter 0.

**26. Veteran's Administration (Educ/Trng Only):** Check yes or no. Enter the amount. If "no", enter 0.

**27. Workers' Compensation:** Check yes or no. Enter the amount. If "no", enter 0.

**28. Other:** Specify any other comparable benefits. Enter the amount. If none, enter 0.

**29. Total:** Enter the sum of Lines 22 through 28. If none, enter 0.

**Comments:** Additional information or explanation may be included in this section.

**Individual and Counselor Signature:** The electronic date and signatures of the individual and the counselor indicate understanding of, and agreement.

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**IPE**

Name:

SSN:

Date of Birth:

Plan Number:

Type of Plan:

Employment Goal:

Plan begins on  and is estimated to end on

Projected Job Demand:

All the Planned Services have been Completely Provided on:

Intermediate Objective:

Method of Measurement:

Intermediate Objective:

Method of Measurement:

Intermediate Objective:

Method of Measurement:

Service:

Provider:

No. Units:  Unit :  Unit Price:

Funded By (Pick one or more when applicable)

Cost:

Cost:

Service Dates:  -

Method for Procuring Service:

Outcome:

Outcome Date:

Service:

Provider:

No. Units:  Unit:  Unit Price:

Funded By (Pick one or more when applicable)

Cost:

Cost:

Service Dates:  -

Method for Procuring Service:

Outcome:

Outcome Date:

Service:

Provider:

No. Units:  Unit :  Unit Price:

Funded By (Pick one or more when applicable)

Cost:

Cost:

Service Dates:  -

Method for Procuring Service:

Outcome:

Outcome Date:

Plan Estimated Cost:

Individual's Contribution:

Total Agency Supplementation:

**Benefits Counseling**

**Worker Assignment**

Assigned to:

Start Date:

End Date:

Primary?

**ACTI assignment:**

**Worker Assignment**

Assigned to:

Start Date:

End Date:

Primary?

**INDIVIDUAL UNDERSTANDINGS, RESPONSIBILITIES, RIGHTS, REMEDIES, AND INFORMED CHOICE**

An individual is eligible for Rehabilitation Services when it is determined the individual has a physical or mental disability which constitutes or results in a substantial impediment to employment; can benefit from Vocational Rehabilitation in terms of an employment outcome; and requires Vocational Rehabilitation Services to prepare for, secure, retain, or regain employment.

A period of trial work experiences may be required when an individual has a physical or mental disability that constitutes or results in a substantial impediment to employment, but it cannot be determined if he/she can benefit from Vocational Rehabilitation Services in terms of an employment outcome.

For each person who is eligible for vocational rehabilitation services or for trial work experiences, an Individualized Plan for Employment (IPE) will be developed by the individual, or the individual's representative if appropriate, with or without assistance from a qualified Vocational Rehabilitation Counselor or technical assistance if required. It will include the specific employment outcome chosen by the individual, consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, in an integrated setting to the maximum extent appropriate. It will also include a description of the specific Vocational Rehabilitation services needed to achieve the employment outcome; timelines for achievement of the employment outcome and initiation of services; the vendors and method of procuring services chosen by the individual; criteria to evaluate progress toward achievement of the employment outcome; and terms and conditions of the IPE, including the responsibilities of the Agency and of the individual. If applicable, information about projected need for rehabilitation technology, personal care assistance, supported employment, or post-employment services will be included.

There will be periodic evaluations of the progress toward the employment outcome, and a review will be conducted at least every 12 months. In some plans, changes may be necessary to take care of circumstances that cannot be foreseen. Some plans may be ended prior to completion if there is no longer a need for services because of new information or changed conditions, or if it is determined that the individual can no longer benefit from services in terms of an employment outcome.

It is the responsibility of the eligible individual to cooperate in the program and make a reasonable effort to carry out the conditions. This includes, but is not limited to, keeping appointments, attending scheduled activities, attaining acceptable ratings in training and other activities, and carrying out medical and other professional instructions. It is also the responsibility of the individual to report to the Rehabilitation Counselor any changes in financial circumstances or the availability of assistance from other programs to meet, in whole or in part, the cost of services provided under the IPE. Failure to do so may result in suspension of further services.

If dissatisfied with any decision by ARS with regard to the furnishing or denial of Vocational Rehabilitation Services, the individual may file a request for review of the decision. The individual has the right to request a due process hearing before an impartial hearing officer. This request must be filed within ten (10) working days of any contested decision. A due process hearing before an impartial hearing officer will be scheduled within 45 days of documented request. The individual has the right to request administrative review or mediation to attempt to resolve the issue within the due process time frame. The qualified impartial mediator or hearing officer is randomly selected by the individual from a list provided by ARS. Any request for the review of a decision must be filed in writing with the Commissioner, or designee, Arkansas Rehabilitation Services, P. O. Box 3781, Little Rock, Arkansas 72203.

A Client Assistance Program (CAP) is available to provide assistance in informing and advising all applicants for services of available benefits under the Rehabilitation Act. Upon request, the CAP may assist each individual in his/her relationship with the projects, programs, and facilities providing services under the Rehabilitation Act, including assistance in pursuing legal, administrative, or other appropriate remedies to ensure the protection of rights under this Act. Individuals who wish assistance from the Client Assistance Program should contact Disability Rights Center, 1100 North University, Suite 201, Little Rock, Arkansas 72207, telephone number (501) 296-1775 or (800) 482-1174.

All services provided by the Arkansas Rehabilitation Services are provided on a non-discriminatory basis without regard to sex, race, age, color, religion, national origin or disability. I understand that with the exception of diagnosis, counseling and guidance, placement and follow-up, other services provided by the Arkansas Rehabilitation Services will be based upon my financial resources and other comparable benefits available to me. I understand that assessment and services are dependent on the availability of funds. If funding is not available, services may not be provided. I understand that if I believe I have been discriminated against, I have the right to file a written complaint with the Commissioner, Arkansas Rehabilitation Services, or designee, P. O. Box 3781, Little Rock, Arkansas 72203, 501-296-1600.

**I UNDERSTAND MY RESPONSIBILITIES AND THE TERMS AND CONDITIONS OF THIS INDIVIDUALIZED PLAN FOR EMPLOYMENT. I HAVE PARTICIPATED IN THE DEVELOPMENT OF THIS INDIVIDUALIZED PLAN FOR EMPLOYMENT AND HAVE REQUESTED THE NECESSARY SERVICES TO MEET MY SPECIFIC EMPLOYMENT OUTCOME/IL GOAL. I HAVE READ OR HAVE HAD EXPLAINED TO ME THE PREPRINTED INFORMATION AND UNDERSTAND AND AGREE TO DO MY BEST TO FULFILL THESE OBLIGATIONS. I HAVE ALSO PARTICIPATED IN AN ASSESSMENT OF THE EXPECTED NEED FOR POST-EMPLOYMENT SERVICES FOLLOWING THE PROVISION OF THE SERVICES LISTED ABOVE. THE PROVISION OF POST-EMPLOYMENT SERVICES MAY NOT EXCEED EIGHTEEN (18) MONTHS.**

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

Printed On:

## INDIVIDUALIZED PLAN FOR EMPLOYMENT (IPE) INSTRUCTIONS

Complete all sections of the IPE in the electronic case management system.

1. The individuals' name, SSN and the date of birth is automatically in the plan.
2. Employment Goal - Select from the dropdown box based on the individuals desired goal, skills and abilities
3. Plan begins on enter the dates 00/00/0000 and the estimated end on 00/00/0000. Enter the dates. **Enter the Annual Review Date.**
4. Projected Job Demand Select from the dropdown box the.
5. "All the Planned Services have been Completely Provided on:" complete when the IPE services have been completed.
6. Intermediate Objectives - List in the order of anticipated completion.
7. Evaluation Criteria - List the measuring tools to determine the progress of the IPE services toward an employment outcome.
8. Service: Select from the dropdown box the service to be provided.  
(**Note:** For each planned service follow #8-15.)
9. Provider: Select from the dropdown box what entity/agency is responsible to provide the service. **NOTE:** If the provider is not in the case management system communicate with the help desk for instructions to add them or an additional service.
10. Enter the Cost of Planned Services: No. of Unit, type of unit and unit price complete and the case management system will total the cost. (The units reflect the cost of planned services.)

Consumer Contribution:

**Cost Estimate** – Reference the RS-16 to determine if the individual has available resources or comparable benefits (i.e. Pell Grant) to contribute toward each service.

If resources are available, the counselor will negotiate with the individual the amount of their contribution and the agency supplementation. These amounts are entered under "Funded By."

11. Funded By: - Select from the dropdown box who will pay for each service. If a contribution is to be made choose the appropriate payer and in the cost box place the amount. For example:

Consumer \$100  
Pell Grant \$100  
Our Agency \$1000

12. Service dates – type in dates 00/00/0000

13. Method of Procuring – select from dropdown.

Explanation:

Purchased - ARS will pay for the services.

Provided - ARS will provide the service.

Arranged - Service will be provided by another source

14. Outcome – select from dropdown.

15. Outcome Date– Once the outcome is completed, type in date 00/00/0000.

16. Total, Individual's Contribution, Total Agency Supplementation: The case management automatically calculates these boxes based on information previous entered.

17. Benefits Counseling or ACTI assignment - If appropriate, select from the dropdown list and enter the dates. Click Resend Assignment.

18. **INDIVIDUAL UNDERSTANDINGS, RESPONSIBILITIES, RIGHTS, REMEDIES, AND INFORMED CHOICE** – Provide to the individual to read, sign and date.

Electronic signature, approved "Y" and date REQUIRED by the Vocational Rehabilitation Counselor, appropriate approval staff and the individual.

The electronic date and signatures of the individual and counselor indicate understanding of, and agreement to the plan.

19. Provide a copy to the individual.

## **INDIVIDUALIZED PLAN FOR EMPLOYMENT AMENDMENTS INSTRUCTIONS**

The original IPE form is used for amending the individual's plan whenever a change in the rehabilitation program is needed and to record the progress of the individual's rehabilitation program annually. A justification notation should be made in the case note to explain the need for an amendment or annual review consistent with informed choice. The counselor will complete only the items needed to accomplish the amendment or annual review. An amendment to the IPE may include a vocational objective change, deletion or addition of services, costs of services, termination of the case, extension of an expired IPE, etc. and the required annual review.

1. **INDIVIDUAL UNDERSTANDINGS, RESPONSIBILITIES, RIGHTS, REMEDIES, AND INFORMED CHOICE** – Provide to the individual to read, sign and date.

Electronic signature, approved "Y" and date REQUIRED by the Vocational Rehabilitation Counselor, appropriate approval staff and the individual.

The electronic date and signatures of the individual and counselor indicate understanding of, and agreement to the plan amendment.

2. Provide a copy to the individual.

Request for HSRC/ACTI Services

Name:

Date of Birth:

SSN:

Employment Goal:

Date this job goal will be achieved:

Field Office:

Referring Counselor:

Counselor #:

Physical Impairment:

Cause of Primary Impairment:

Other Impairment:

Cause of Other Impairment:

Has Client Been Served at HSRC/ACTI Before?

If Client has medical or private insurance please attach copy of card front and back.

Contribution/Payment Source:

Plan for Payment of Comparable Benefits:

**PLANNING INFORMATION**

Explanation of Rehabilitation Problem:

Work Goal / Job Specific:

Please evaluate the needed client service; check appropriate boxes  
In order of Priority, list the services you need us to provide the client.

Service:

Service:

Service:

**Information Attached**

- RS-4 / S.S. Card
- Current Medical Reports
- Current Specialists Reports
- Current Psychological Test Results
- Current Case Narratives
- Current Prescriptions / Special Diet
- IPE / Amendment
- ARS-75
- Parental Consent / Guardianship
- Signed Student Conduct Standards
- RS-16 Financial / Resource
- RIDAC
- Immunization Records

**Resident**

- Non-resident
- Smoker
- Non-smoker
- Wheelchair
- Other Special Need Specifically

Please attach the information that you have  
or click on the attached documents to view them.

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

## REQUEST FOR ACTI/HSRCH SERVICES INSTRUCTIONS

1. **Name:** Individual's last name, first name, and middle initial.
2. **Social Security Number:** Record client's social security number. Verify the number by checking the client's Social Security card.
3. **Referring Counselor:** Record last name only.
4. **Counselor Number:** Record field counselor's number.
5. **Primary and Secondary Disabilities:** List primary and all secondary disabilities with codes for each.
6. **Describe Status of Disability:** Complete if applicable. **Example:** Seizure disorder controlled by medication.
7. **Prior ACTI/HSRCH Services:** Dates of previous admissions and services received if known.
8. **Contribution/Amount/Payment Source:** Include the amount of contribution, frequency of contribution and name and address of the contributor to be billed if other than client.
9. **Plan for Payment of Comparable Benefits:** List all funding sources including name, address, and payment plan. **Example:** Worker's Compensation, Aetna Insurance Company, Medicaid (attach copy of current card with number), etc. and billing address.
10. **Planning Information:**
  - **Explanation of Rehabilitation Problem:** This section should adequately identify and describe the rehabilitation problem in reference to the client's functional capacities and limitations and their implications in relation to his/her work potential. The rehabilitation problem is not the diagnosis or disability.

Rehabilitation problems are behaviors or conditions exhibited behavior or for conditions exhibited by individuals and/or presented by their environment which need to be eliminated or improved in order for the individuals to fulfill their vocational potential or maximize their work functioning.

Description of the rehabilitation problem should provide specific information related to the following questions:

1. Why is the individual not working?
2. What is preventing the individual's obtaining, retaining, or preparing for employment?
3. What are the specific functional limitations and restrictions imposed by the disability and how do these limitations and restrictions affect vocational functions and activities?

- **Statement of How ACTI Services are Expected to Improve Individual's Employment/Placement Potential:** The statement or information provided in this section should be linked to the explanation of the rehabilitation problem; i.e. what is the expected outcome of ACTI services in reducing, eliminating, or modifying the identified rehabilitation problem(s). Expectations should be stated in terms of improved or modified functional capacities related to the disability, not a change in the disabling condition itself. The expected, or desired, outcomes should be stated for each service requested.
- **Services Requested:** Place a number in boxes to identify services requested and probable sequence of services.
- **Information Attached:** Check appropriate box for documents attached to the Request for ACTI/HSRCH Services Form. These documents will be utilized for admissions information and program planning.
- **Residential Information:** Check appropriate boxes.
- **Counselor Signature and Date:** Counselor will sign and record the date the form is completed.

**ARKANSAS REHABILITATION SERVICES  
AUTHORIZATION FOR ADJUSTMENT/EXTENDED SERVICES DAYS/  
90-DAY CLOSURE INSTRUCTIONS**

Check one

- Work Adjustment  
 Extended Services  
 Job Placement (SSBG 26 Closure)

---

Client's Last Name                      First Name      Initial                      Case Number/SSN

I authorize \_\_\_\_\_  
   Vendor Name

to provide Adjustment Services related to Work Adjustment, SSBG Extended Services Days, or Job Placement (SSBG 26 Closure) effective \_\_\_\_\_. I have reviewed and approved a Service Plan submitted by the Community Rehabilitation Program staff.

The Plan contains:

1. Documentation of client's involvement in plan development.
2. An acceptable overall goal which names the ultimate purpose of this phase of programming. It is stated in specific terms of competitive employment, Work Adjustment Services, SSBG Extended Services days, Job Placement Services (SSBG 26 Closure), other training, (i.e., ACTI, on job training, specific skills training, Supported Employment Services or other vocational training.)
3. Program goals stated in terms of how the overall goal will be achieved.
4. Measurable objectives leading toward achievement of each program goal.
5. Target dates for beginning and completion of all goals and objectives.
6. The name of the CRP staff member who has the responsibility to coordinate the rehabilitation process, provide monthly reports and change the plan when necessary.

---

Counselor's signature

Date

Distribution: ECF Local Office  
   ARS Community Program Development Section  
   CRP Client file

**ARKANSAS REHABILITATION SERVICES  
AUTHORIZATION FOR ADJUSTMENT/EXTENDED SERVICES DAYS/  
90-DAY CLOSURE INSTRUCTIONS**

The Authorization for Adjustment Services/Extended Services Days/90-Day Closure will be completed by the Counselor to authorize an individual to receive up to sixty (60) days of Work Adjustment in a CRP or additional training days through Extended Services Days or 90-Day Closure (Job Placement) Service.

Based on the need of the client as reported provided by the CRP, the counselor will complete the RS-315 for either Work Adjustment, Extended Services Days or 90-Day (Job Placement) Closure Service as appropriate Service time frames and fees are set out in a contract with a Community Rehabilitation Program and funded under Title XX SSBG.

# **TRAINING PROGRESS REPORT INSTRUCTIONS**

(Next three forms.)

## **RESPONSIBILITY OF COLLEGE STUDENTS**

This form is to be completed by all individuals participating in a college program. The report is signed by the individual and the counselor and attached to the ECF and a copy is provided to the individual.

**LETTERS FOR STUDENTS FOR TRAINING** – The counselor will mail the letter during the Spring Semester.

**TRAINING PROGRESS REPORT** – This form is to be completed by the instructor.

STATE OF ARKANSAS

Mike Beebe  
Governor

Bill Walker  
Director



Arkansas Career Education  
Division of Rehabilitation Services  
Randy Lavery , Commissioner

http://www.arsinfo.org  
An Equal Opportunity Employer

**Responsibilities of College Students**

You have been accepted for assistance in college training by the Arkansas Rehabilitation Services. Continued assistance will depend upon your cooperation and acceptance of the following responsibilities.

A. You will be expected to apply for Student Financial Aid on an annual basis and provide copies of the results to this office.

B. Reports to your counselor:

Name	
Address	

1. Immediately after enrollment and registration, report the following
  - a. Title of each course and number of credit hours for each.
  - b. Address of school, including street address or dormitory and room number.
  - c. Any problems encountered affecting registration or enrollment.
2. The second report is due at the end of the first grading period such as four weeks, six weeks or nine weeks and must include the grade received in each subject.
3. The third report will be due at the end of the semester or term and will include your final grade for each course. This is your report and not the official college report. You will be able to obtain your grades before they are posted in the Registrar's Office and these can be used for your report.

The reports listed above will be required for each semester or term.

C. Other responsibilities:

1. It is required that each full-time student carry a minimum load of 12 semester hours. Enrollment in less than 12 semester hours is permissible only upon special written permission from your counselor prior to enrollment. You will be expected to maintain a "C" average per semester.
2. Any anticipated change in your major field of study or vocational objective must be reported to your counselor.
3. Dropping of any course or dropping out of school must be reported.
4. Any disciplinary action in which you are involved must be reported to your counselor.
5. You must make arrangement for a personal contact with your counselor during the summer months to evaluate your progress.
6. Upon completion of your college work, it is your responsibility to keep in touch with your counselor and notify him/her when you accept employment.

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Individual's Signature	Date	Counselor's Signature	Date
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## LETTER FOR STUDENTS IN TRAINING

Dear \_\_\_\_\_ :

This is a reminder that in order for us to meet Federal and State Guidelines for you to receive assistance from our Agency, you must comply with the following:

1. Apply for the Student Financial Aid on an annual basis and send a copy of the award or denial letter for your file.
2. Final grades from the last semester in school or a copy of your transcript showing your final grades must be forwarded to me for your file.
3. Maintain a 2.0 grade point average per semester while enrolled as a full-time student.
4. Arrange to meet with me once following the Spring Semester and at least one month prior to the Fall Semester to accomplish an annual review.

Failure to comply with these guidelines will result in denial of tuition assistance to you.

Sincerely,

\_\_\_\_\_, Rehabilitation Counselor  
Arkansas Rehabilitation Services

## ARKANSAS REHABILITATION SERVICES MONTHLY TRAINEE LETTER

(At the end of each month the trainee may be required to contact the counselor by phone, email or letter to discuss your progress in training, difficulties you may be having and any other statements you care to make concerning your preparation for employment.)

---

Date \_\_\_\_\_  
Started Training \_\_\_\_\_  
List Absences: \_\_\_\_\_

Trainee \_\_\_\_\_  
Present Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Reentered: \_\_\_\_\_

(IF YOU NEED MORE SPACE USE THE BACK SIDE OF THIS SHEET.)

**ARKANSAS REHABILITATION SERVICES**

**TRAINING PROGRESS REPORT**

NOTE—THIS REPORT MUST ACCOMPANY ANY CLAIM FOR PAYMENT OF TUITION OR OTHER CHARGES

Name of Trainee \_\_\_\_\_ Month ending \_\_\_\_\_

Name of Course \_\_\_\_\_

- 1. Number of Days Present—(For full-time trainee) \_\_\_\_\_ days of \_\_\_\_\_ days offered.  
 Number of Hours Instruction Given—(For part-time or tutorial) \_\_\_\_\_ hours of \_\_\_\_\_ hours offered.

Check with "X" the word or words best describing items 2, 3, 4, 5, and 6

- 2. Regularity of Attendance—This month:
  - No time lost . . . . . \_\_\_\_\_
  - Occasional absences (3 or less.) . . . . . \_\_\_\_\_
  - Irregular (4 or more) . . . . . \_\_\_\_\_
  - Were absences excusable? Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Status of Trainee—This report:
  - In training . . . . . \_\_\_\_\_
  - In training but ready for job . . . . . \_\_\_\_\_
  - In employment . . . . . \_\_\_\_\_
  - Discontinued . . . . . \_\_\_\_\_

- 4. Progress This Month:
  - Accelerated . . . . . \_\_\_\_\_
  - Average . . . . . \_\_\_\_\_
  - Slow . . . . . \_\_\_\_\_
  - No progress . . . . . \_\_\_\_\_
- 5. Quality of Work:
  - Excellent . . . . . \_\_\_\_\_
  - Good . . . . . \_\_\_\_\_
  - Fair . . . . . \_\_\_\_\_
  - Poor . . . . . \_\_\_\_\_
- 6. Cooperation in Training
  - Cooperative . . . . . \_\_\_\_\_
  - Fairly cooperative . . . . . \_\_\_\_\_
  - Indifferent. . . . . \_\_\_\_\_
  - Not cooperative. . . . . \_\_\_\_\_

7. Difficulties (If any, check below and explain briefly on back of this form):

- (a) With training course: \_\_\_\_\_
  - Learning subject matter \_\_\_\_\_
  - Following instructions \_\_\_\_\_
  - Handling tools or machines \_\_\_\_\_
  - Speed \_\_\_\_\_
  - Accuracy \_\_\_\_\_
- (b) Other difficulties: \_\_\_\_\_
  - With disability \_\_\_\_\_
  - With appliance \_\_\_\_\_
  - With general health \_\_\_\_\_
  - With other (Describe) \_\_\_\_\_

8. Subjects or Operations This Month—With grades (If in employment training, rate performance as Good, Fair, or Poor):

Subjects or Operations	Grade or Rating	Subjects or Operations	Grade or Rating
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. In your judgment, does trainee have the talent, personality, education and other qualifications necessary to succeed in this kind of work? \_\_\_\_\_ If not, explain: \_\_\_\_\_

10. Has trainee begun to earn a wage? \_\_\_\_\_

11. How much more time will trainee require (approximately) to complete training? \_\_\_\_\_

12. Recommendations for improving performance \_\_\_\_\_

Training Agency \_\_\_\_\_

Address \_\_\_\_\_

(Date) \_\_\_\_\_ (Signed) \_\_\_\_\_

Officer or Instructor in Charge

**ARKANSAS REHABILITATION SERVICES  
STUDENT HEALTH SURVEY**

STUDENT'S  
NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

COUNTY: \_\_\_\_\_ PHONE: \_\_\_\_\_ HIGH SCHOOL: \_\_\_\_\_  
City Zip Code

FAMILY DOCTOR: \_\_\_\_\_

The purpose of this form is to help us locate any student with physical, mental, and/or other problems that may qualify for assistance with a program of vocational training – college or university, business, trade school, or other types of training, and other rehabilitation services.

Are you excused from Physical Education because of medical reasons? \_\_\_\_\_

If Yes, why? \_\_\_\_\_

Are you in Special Education? \_\_\_\_\_ Do you have a drug or alcohol problem? \_\_\_\_\_

Do you have any of the following problems?

Mental \_\_\_\_\_ Physical/functional \_\_\_\_\_ or emotional \_\_\_\_\_

PLEASE CHECK BELOW ANY OF THE FOLLOWING CONDITIONS OR DISEASES WHICH NOW CAUSE YOU SOME LIMITATION OR DIFFICULTY.

- |                                 |                            |
|---------------------------------|----------------------------|
| _____ Deafness (or)             | _____ Asthma, severe       |
| _____ Severe Hearing Loss       | _____ Cancer               |
| _____ Speech Problem, severe    | _____ Osteomyelitis        |
| _____ Mental /Emotional Problem | _____ Heart Impairment     |
| _____ Learning Problem          | _____ Lung Impairment      |
| _____ Drug/Alcohol Problem      | _____ Arthritis            |
| _____ Epilepsy                  | _____ Curved Spine         |
| _____ Tuberculosis              | _____ Physical Deformities |
| _____ Sickle Cell Anemia        | Specify _____              |
| _____ Diabetes                  | _____ Amputation           |
| _____ Overweight, severe        | Specify _____              |
| _____ High Blood Pressure       | _____ Other                |
| _____ Rheumatic Fever           | Specify _____              |

PLEASE LIST AND EXPLAIN ANY OTHER CONDITIONS OR PROBLEMS NOT LISTED ABOVE:

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Use back for additional information

I understand this information will be used exclusively for the purpose of determining eligibility for Vocational Rehabilitation Services via Arkansas Rehabilitation Services (ARS); thus will be shared with the VR Counselor assigned to serve my high school.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# RECEIPT/RELEASE FOR OCCUPATIONAL TOOLS AND/OR EQUIPMENT AND TITLE AGREEMENT INSTRUCTIONS

Name: \_\_\_\_\_  
(Last, First, MI) Social Security Number

Date: \_\_\_\_\_

Received of the Rehabilitation Services the following property: i.e. durable medical equipment, educational tools, occupational equipment, etc):

Receipt of the items listed above is hereby acknowledged, and it is understood that such property has been supplied sole for the rehabilitation of the undersigned, who agrees to keep such property in good condition and available for inspection at all reasonable times, and recognizes that the right and title to the occupational tools and/or equipment is vested in the Rehabilitation Services until such time as title may be released. It is understood that this property is not to be mortgaged, sold, given away, or in any way disposed of until title is released by Arkansas Rehabilitation Services. If, before title is released, the property is no longer being used for the purpose for which it was provided, it shall be returned to the Rehabilitation Services.

RECEIVED

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

RELEASED

\_\_\_\_\_  
SIGNATURE OF COUNSELOR

\_\_\_\_\_  
DATE

## **RECEIPT/RELEASE FOR OCCUPATIONAL TOOLS AND/OR EQUIPMENT AND TITLE AGREEMENT INSTRUCTIONS**

This form will be attached to the ECF and a copy provided to the individual.

Complete all sections in the electronic case management system.

1. Record the month, day, and year.
2. List in detail, the items purchased for the individual and describe each item, showing serial numbers, if applicable.
3. The electronic date and signatures of the individual (the same name in the ECF.) and counselor indicate understanding of, and agreement to the title of the tools/equipment.

# EMPLOYMENT SERVICES REFERRAL

Referral date \_\_\_\_\_  
Name \_\_\_\_\_ SSN/Case Number \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_ New/Reopen \_\_\_\_\_  
Telephone \_\_\_\_\_ Message Phone \_\_\_\_\_  
Referral Counselor \_\_\_\_\_  
Primary Disability \_\_\_\_\_  
Vocational Objective \_\_\_\_\_ Code \_\_\_\_\_ Date Available \_\_\_\_\_ Location Preferred \_\_\_\_\_

**The top portion of this form should be completed by the referring counselor.**

Severe?  Yes  No SSI?  Yes  No Amount? \_\_\_\_\_ SSDI?  Yes  No Amount? \_\_\_\_\_  
Restrictions \_\_\_\_\_  
Level of education complete \_\_\_\_\_ Race \_\_\_\_\_  
Veteran?  Yes  No ACTI Client?  Yes  No Date \_\_\_\_\_ Transportation  Yes  No  
Unemployed before entry into project?  Yes  No Number of months? \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge and I hereby authorize the release of any information concerning my employment potential to prospective employers.  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Employment plans

Business Relations Representative (BRR) \_\_\_\_\_ Date Interviewed \_\_\_\_\_

Copy to counselor before interview.  
Original copy in the Business Relations Representative Main Office after interview.  
Copy remains in Business Relations Representative file.

# EMPLOYMENT SERVICES REFERRAL FORM INSTRUCTIONS

This form is used for all job placement referrals to the ARS Business Relations Representative (BRR.)

1. The counselor will complete the top half of the form.
2. The bottom half will be complete by Business Relations Representative.

## **Distribution (Field Office)**

- Copy of the referral form is attached to the ECF.
- A copy of the referral form remains in the file of the Business Relations Representative.
- After the client interviews for possible employment, the Business Relations Representative completes the form and a copy of this form is attached to the ECF.

## **Distribution (ACTI)**

- Copy of the referral form is in the ACTI client file at referral
- A copy of the referral form remains in the file of the Business Relations Representative.
- After the clients interview for possible employment, Business Relations Representative completes the form and a copy of this form is retained in the ACTI counselor's file and the field counselor's file.

VR Case and Closure/Amendment Information

Client Name: [ ]

Date of Birth: [ ]

Is Client Working? [ ]

Level of Education at Closure:

[ ]

Student with Disability in Secondary Education at Closure:

[ ]

**Impairments**

Primary Impairment: [ ]

Cause of Primary Impairment: [ ]

Other Impairment: [ ]

Cause of Other Impairment: [ ]

Significantly Disabled?  
Significance of Disability: [ ]

Projects with Industry (IAM CARES, etc.)?

**Other Income at Closure**

Please Enter Monthly Amount

**AMOUNT**

- [ ] SSI Aged
- [ ] SSI for the Disabled
- [ ] Temporary Assistance for Needy Families (TANF)
- [ ] General Assistance (State or Local Government) NOT FEDERAL
- [ ] Social Security Disability Insurance (SSDI)
- [ ] Veteran's Disability Benefits
- [ ] Worker's Compensation
- [ ] Family and/or Friends
- [ ] Other Public Assistance
- [ ] Free or Reduced Lunch Program

Primary Source of Support at Closure

[ ]

**Employment Closure Information**

**Employment Information**

Primary?

Occupation:

Job Title:

Department:

Start Date:

End Date:

Work Status:

Employer's Name:

Employer's Address:

Pay Period:

Amount:

Hours per week:

Days Per Week:

Hourly wage

Weekly Wage

Annual Wage

Is this wage comparable with other people for the same job with the same employer?

Medical Benefits (including waiting time, if any):

Physical, cognitive and social demands:

Accommodations, Supports or Specialized Strategies:

Duties and Skills:

**Pg 3 VR Case and Closure/Amendment Information**

Job Modifications:

Reason For Leaving:

Comments:

Contact employer?

If Used:

CRP Vendor:

ACTI:

Type of ACTI services provided:

Complete?

Primary?

Occupation:

Job Title:

Department:

Start Date:

End Date:

Work Status:

Employer's Name:

Employer's Address:

Pay Period:

Amount:

Hours per week:

Days Per Week:

Hourly wage

Weekly Wage

Annual Wage

Is this wage comparable with other people for the same job with the same employer?

Medical Benefits (including waiting time, if any):

Physical, cognitive and social demands:

Accommodations, Supports or Specialized Strategies:

Duties and Skills:

Job Modifications:

Reason For Leaving:

Comments:

Contact employers?

If Used:

CRP Vendor:

ACTI:

Type of ACTI services provided:

Complete?

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**Federal Reported Information**

Work Status:

Pay Period:

Amount:

Hours per week:

# of Jobs:

Days per week:

Earned:

Integrated Work Setting:

Supported Employment Status at Closure:

Supported Employment Goal:

Migrant and Seasonal Farmworker:

**Medical Insurance Coverage at Closure:**

- Any Medical Insurance at Closure?
- Medicaid?
- Medicare?
- Public Insurance from Other Sources?
- Private Insurance Through Own Employment?
- Private Insurance Through Other means?
- Not Yet Eligible for Private Insurance through Current Employer ?

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Reason Services on Plan were not provided:

Reason for closure:

Date Closed:

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SIGNATURE

---

Date

---

SIGNATURE

---

Date

---

Federal Report Information

Zip:  County:

**Pg 3 VR Case and Closure/Amendment Information**

Date: \_\_\_\_\_

Dear

You have recently been provided services in an effort to help you continue in your employment or to help you return to employment.

I would like for you to fill out the following Employment Questionnaire and return it to me in the enclosed self-addressed envelope.

1. Do you work regularly? \_\_\_\_\_

2. What is your job? \_\_\_\_\_

3. Where are you working? \_\_\_\_\_  
(Name and address of employer)  
\_\_\_\_\_

4. What is your weekly pay? \_\_\_\_\_

5. When did you start working? \_\_\_\_\_

6. Are you a Homemaker? If so, are you now able to perform your homemaking duties? Yes \_\_\_\_\_ No \_\_\_\_\_

7. Are you an Unpaid Family worker in the home? Yes \_\_\_\_\_ No \_\_\_\_\_

8. REMARKS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Please return as soon as possible

## REGISTERED LETTER - CLOSURE OF CASE RECORD OF SERVICES

Dear

This Registered Letter is to inform you that your ARS file is being closed since you are employed. A minimum of three written attempts (2 letters with one registered letter) has been made to contact you about closure of your case. The Code of Federal Regulations (Part 361.34, Section 361.56) states the case record of services of an individual who has achieved an employment outcome may be closed if the following requirements have been met:

- (A) Employment outcome achieved. The individual has achieved the employment outcome that is described in the Individual's Individualized Plan for Employment that is
  - (1) Consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; and
  - (2) In the most integrated setting possible, consistent with the individual's informed choice.
- (B) Employment outcome maintained. The individual has maintained the employment outcome for an appropriate period of time, but not less than 90 days, necessary to ensure the stability of the employment outcome, and the individual no longer needs vocational rehabilitation services.
- (C) Satisfactory outcome. At the end of the appropriate period under paragraph (B) of this section, the individual and vocational rehabilitation counselor considers the employment outcome to be satisfactory and agree that the individual is performing well in the employment.
- (D) Post-employment services. The individual is informed of the availability of post-employment services.

If notice to the contrary is not received from you within five working days from the date of the receipt of this letter, I will consider the requirements met and your case will be closed. If you have any questions or concerns, please contact me.

Sincerely,

Counselor  
Arkansas Rehabilitation Services

# STATE OF ARKANSAS



## Department of Career Education Arkansas Rehabilitation Services

### Consumer Satisfaction

We are always trying to improve our services by listening to our consumers and getting their opinions on how well we are doing. To protect the respondents' identity, an external evaluator will log the responses. Your ratings and those of other consumers will be grouped together so that the sources of the ratings remain strictly confidential.

Given your experiences with Arkansas Rehabilitation Services delivery system, would you please rate them on the following: **Please circle only one number for each aspect.**

Aspects	Low				High
1. Counselor's efforts to involve you in making decisions about your rehabilitation program	1	2	3	4	5
2. Counselor's efforts to listen to your ideas and suggestions about the job you would like to have	1	2	3	4	5
3. Counselor's efforts to involve you in making decisions about the services you need.	1	2	3	4	5
4. Counselor's efforts to involve you in choosing service providers.	1	2	3	4	5
5. Your satisfaction with the services you received.	1	2	3	4	5
6. The speed with which the services got started.	1	2	3	4	5
7. Your satisfaction with your interaction with the counselor.	1	2	3	4	5
8. Your satisfaction with your interaction with service providers other than VR.	1	2	3	4	5
9. Your satisfaction as to how sufficient these services were in helping	1	2	3	4	5
10. Counselor's / VR efforts to help you find a job.	1	2	3	4	5
11. Counselor's efforts to keep in touch with you after your case was closed to make sure you did not need more services.	1	2	3	4	5
12. Counselor's VR ability to help you in general.	1	2	3	4	5
13. Are you using accommodations or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	1	2	3	4	5
If yes, rate the counselor's efforts in helping you get these.	1	2	3	4	5
14. Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you are working, rate your satisfaction with your job.	1	2	3	4	5

**Thank you for completing the form. Please fold and tape it to show Arkansas Rehabilitation Services address and drop it in the mail.**

525 West Capitol Avenue ♦ Little Rock, AR 72201 ♦ (501) 296-1600 ♦ TDD (501) 296-1669 ♦ Fax (501) 296-1141  
<http://www.arsinfo.org> ♦ An Equal Opportunity Employer

## **CONSUMER SATISFACTION SURVEY INSTRUCTIONS**

This form is to be mailed to the individual at the time of closure (Status 26 and 28) or accessed online. The original form is postage paid so copies cannot be used.