

APPENDIX E FORMS AND INSTRUCTIONS

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See Appendix C. Community Rehabilitation Programs for forms on Supported Employment and Job Services-VR Only (Placement)

CHECKLIST = TECHNICAL ASPECTS OF THE CASE

Client Name

Social Security Number

APPLICATION

- Informed consent form (if under 18 years of age)
- Completed RS-4 Application dated and signed by individual.
- Signed Substance Abuse Policy Acknowledgment
- Voter Declaration Statement signed by individual.
- Copy of completed Release of Information
- Intake Narrative (complete with referral information, work history, counselor or rehabilitation assistant observations, plan of action, diagnosis, Client Handbook was provided to the applicant, and statement that demonstrates informed consent.)
- RIDAC Authorization and Medical Form completed.

ELIGIBILITY/ACTIVE

- Presumptive eligibility (SSDI/SSI) verified.
- Supporting documentation for eligibility such as Health reports, SSA program, SSA specialist reports, General Medical Report, Psychological or Mental Psychologist, psychologist, counselors, treatment.
- Case narrative and limitations.
- A Certificate of Eligibility
- Completed Application
- Notification
- Case Narrative document
- Completed Application
- Completed IF and signed by an individual (and dated) benefits and verification to be used. The I-9 completed (and dated) of E. ed cost, comparable to the C
- Student Financial Aid documented, if applicable.
- Documentation of training progress and case.
- Signed Annual Review Amendment.

CLOSURE

- Case Narratives
- Documentation of employment.
- Signed 600-C with Informed Choice
- Letter to individual informing of A and information about post-employment services.
- Three (3) written attempts to contact (2 in registered letter).
- Registered Letter signature card.
- Client Satisfaction Survey.

Counselor Signature

Date

CHECKLIST INSTRUCTIONS

~~The checklist is a tool for the counselor to use in assuring that all required forms and documentation have been completed. The counselor will check each item as they are completed. The checklist will be filed on the right side of the case folder on the top of the case narrative.~~

~~Form completion is self-explanatory.~~

**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

Elections Division
Voter Services

P.O. Box 8111

682-1-15

Little Rock, Arkansas 72203-8111

1-501-

1-800-

Remember to put your AGENCY Contact Information on all Voter Registration Applications
 Please send completed APPLICATIONS to Secretary of State **DAILY**. Retain all Declination Forms for
 24 months. Send original applications to Secretary of State.
You must retain the year's applications for 24 Months.

Agency: _____ Month/Year: _____

Address: _____ Street _____ City _____

County _____ ZIP Code _____

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	Saturday	Sunday	Total
DATES							
Number of VR Applications							
Number of Declinations							

New Application for Service Agency Grand Total		Number of VR Applications Grand Total		Declinations Grand Total	
--	--	---------------------------------------	--	--------------------------	--



Arkansas Secretary of State
 Voter Registration Site Monthly Reporting Form

Elections Division
 Voter Services

Voter Registration
 P.O. Box 8111
 Little Rock, Arkansas 72203-8111

1-501-682-1686
 1-800-247-3312

Secretary of State

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
Date								
Number of VR Applications								
Number of Declinations								

Week 5	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
Date								
Number of VR Applications								
Number of Declinations								

New Applications for Service Agency Grand Total

Number of VR Applications Grand Total

Declination 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 that the same day.

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 (RS-375)**

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

INFORMED CONSENT INSTRUCTIONS (RS-375)

~~This form is to be completed if the individual applying for services is less than 18 years of age.~~

- ~~1. Self-explanatory~~
- ~~2. A copy must be placed in the case folder.~~

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 _____ Supervisor Signature _____
Date _____ Date _____

CLIENT REFERRAL AND SURVEY INFORMATION (RS-4)

ARKANSAS REHABILITATION SERVICES CLIENT REFERRAL AND SURVEY INFORMATION

1. REFERRAL INFORMATION

SOCIAL SECURITY NUMBER		COUNCIL CODE	AGENCY CODE		CLIENT NAME FIRST MI		STATUS	EFFECTIVE DATE YR/MO/DAY	CURRENT CODE SSDI SSI		
STREET ADDRESS BOX ROUTE					ZIP CODE	CLIENT PHONE NO. AREA CODE /PHONE NUMBER			PHONE TYPE		
FED ERIC PROGRAM CODE	COMP. BENEFITS	D.O.B. YR/MO/DAY	GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		ETHNICITY						
					IRISH <input type="checkbox"/>		AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/>		HISPANIC/LATIN <input type="checkbox"/>		
REFERRAL SOURCE					REFERRAL SOURCE CODE		PRIMARY RACE/ETHNICITY				
							SURVIVAL COVERAGE AT APPLICATION				
							MEDICARE <input type="checkbox"/>		WORKERS' COMPENSATION <input type="checkbox"/>		
							PRIVATE HEALTH INSURANCE <input type="checkbox"/>				
							OTHER MEANS <input type="checkbox"/>				
PRIMARY DISABILITY											
LAST TREATMENT/EXAMINATION N/A <input type="checkbox"/>											
SECONDARY DISABILITY											
LAST TREATMENT/EXAMINATION N/A <input type="checkbox"/>											
PROSTHESIS USED NO <input type="checkbox"/>					KIND		DATE FITTED		CONDITION		
									MANUFACTURER		
PRIMARY PHYSICIANS											
<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced					<input type="checkbox"/> Never Married <input type="checkbox"/> Not Available						
HOUSEHOLD MEMBERS - NAME					RELATIONSHIP		EMPLOYMENT				

LIVING ARRANGEMENT AT APPLICATION	CODE:
FAMILY MONTHLY INCOME	Total Amount:
PRIMARY SOURCE SUPPORT AT APPLICATION	CODE:

PUBLIC ASSISTANCE									
BSN CODE	BSN AMOUNT	SSI CODE	SSI AMOUNT	TANF CODE	OTHER AMOUNT	GA CODE	VET P/B CODE	IND CODE	TOTAL AMOUNT

PERSON(S) THROUGH WHOM CLIENT MAY ALWAYS BE CONTACTED		
NAME	TELEPHONE NUMBER	RELATIONSHIP

HIGHEST GRADE COMPLETED IN HIGH SCHOOL	YEAR	4. EC	NAME OF INSTITUTION	IEP
OTHER TRAINING OR COURSE	YEAR		NAME OF INSTITUTION	<input type="checkbox"/>

CURRENTLY EMPLOYED	PRESENT OR EMPLOYED	MONTHS EMPLOYED	DATE LAST EMPLOYED
<input type="checkbox"/>			

EMPLOYMENT INTEREST	<input type="checkbox"/> YES
PREVIOUS EMPLOYER	

TYPE	CODE	YES
1. PRIVATE INSURANCE COMPANY:	001	<input type="checkbox"/>
POLICY NUMBER:		
2. MEDICAID	002	<input type="checkbox"/>
3. MEDICARE	004	<input type="checkbox"/>
4. STATE WORKERS COMPENSATION	010	<input type="checkbox"/>
5. PELL GRANT	020	<input type="checkbox"/>
6. VA BENEFITS TYPE VETERAN <input type="checkbox"/> YES	040	<input type="checkbox"/>
7. FEDERAL WORKERS COMPENSATION	200	<input type="checkbox"/>
8. CHILDREN'S MEDICAL SERVICES	400	<input type="checkbox"/>
PARABLE BENEFIT CODE TOTAL		

VII. APPLICATION

With informed choice, I hereby make application to the Arkansas Rehabilitation Services for the following services. Assessment of vocational rehabilitation needs including diagnostic and related services have been made available to me.

SERVICES	CHOSEN VENDOR

The requested information is voluntary; however, for a delay or denial of services. The purpose and need for such information is to establish eligibility for a vocational program for the client, and/or determine need for and/or type of treatment.

I am aware that all programs and services provided by the Agency without regard to sex, race, age, color, religion, national origin, guidance, placement and follow-up, other services provided and other comparable benefits available to me. I further understand my Individualized Plan for Employment will determine the change, I agree to notify my vocational rehabilitation counselor.

Services are provided on a non-discriminatory basis and that with the exception of diagnosis, counseling and Assessment Services will be based upon my financial resources of the Agency and myself during the development of financial resources or available comparable benefits.

ARS applicants and eligible individuals receiving services may request an exception should be made directly to the vocational rehabilitation counselor. If dissatisfied with any decision made by ARS with regard to the financial request for review of the decision must be filed within ten (10) working days of any contested scheduled within 45 days of the issue within the due provided by ARS. Any request for review of a decision must be filed with the Arkansas Rehabilitation Services, P. O. Box 378, Little Rock, Arkansas 72203, (501) 485-2000.

The request for an appeal of a specific service provision policy. The request for an appeal should be forwarded to the District Manager for a decision. If the individual is dissatisfied with the decision, the individual may file a request for a hearing before an impartial hearing officer. This request must be filed within ten (10) working days of the date of the decision. The hearing officer will be randomly selected from a list of hearing officers by the client from a list maintained by the Arkansas Rehabilitation Services.

A Client Assistance Plan (CAP) is available under the Rehabilitation Act of 1973, providing services to ensure the protection of the individual's rights. For more information, contact the Client Assistance Center, 1100 North Main Street, Little Rock, Arkansas 72203, (501) 485-2000.

Such information is based on the physical and specific medical information provided by the physician and other appropriate personnel. Such information is based on the physical and specific medical information provided by the physician and other appropriate personnel.

I understand the information provided is based on the physical and specific medical information provided by the physician and other appropriate personnel.

Such information is based on the physical and specific medical information provided by the physician and other appropriate personnel.

I understand and agree to the conditions required by the Arkansas Rehabilitation Services.

operations

I understand that the information provided is based on the physical and specific medical information provided by the physician and other appropriate personnel.

CLIENT SIGNATURE

DATE

CLIENT REFERRAL AND SURVEY INFORMATION INSTRUCTIONS (RS-4)

The RS-4 is a basic document for obtaining common data on all individuals served by ARS and in many instances, may be the most significant form found in the individual case record. This form must contain the basic information from which vital decisions affecting the rehabilitation program of the individual are made. This form is intended to be a working document to be used by the counselor and individual in the development of a rehabilitation program. It will be completed during the initial interview with the individual. All items are to be completely filled out. The completion of the form is self-explanatory, but to insure your understanding, the following information should be studied.

All information should reflect the site of referral.

1. REFERRAL INFORMATION

SOCIAL SECURITY NUMBER: Record the individual's social security number.

COUNSELOR: Record your 3-digit identification number.

AGENCY CODE:

C

32
80

APPLICANT: Enter applicant's name, first name and middle initial. Do not use punctuation or symbols.

STATUS: Enter Status 02.

EFFECTIVE DATE: Record the year and day. This date should be entered in two digits; i.e., January 4, 2002, should be entered as 020104.

SSDI/SSI STATUS HISTORY: Enter appropriate 1-digit code for the SSDI/SSI statuses at referral from the following:

Code	Definition
0	Not an Applicant
1	Applicant allowed benefits as a beneficiary or recipient
2	Applicant denied benefits
3	Applicant - status of application pending
4	Not known if an applicant
5	Benefits discontinued or terminated

0 Not an Applicant - Use Code 0 only for those cases known definitely not to be an applicant for benefits prior to referral. (In the past three years.)

1 Applicant Allowed Benefits - Use Code 1 to report the status of all individuals who are receiving benefits.

2 Applicant Denied Benefits - Use Code 2 to report all individuals who have filed an application for benefits and received notice they have been denied. If the applicant has been denied benefits and has requested reconsideration or appealed the decision, record the case as Code 3, Pending, rather than Code 2, Denied, since the denial was the last official decision and the benefits have been discontinued. Do not use Code 2 if an individual's benefits have been discontinued (See Code 5 below).

3 Applicant Status of Application - Use Code 3 when it is known the status of the application is pending at the time being coded. If the applicant has been denied benefits but has requested reconsideration or appealed the decision, record the case as Code 3, Pending, rather than Code 2, Denied, since the denial was the last official decision and the benefits have been discontinued. If the appeal is not yet decided, record the case as Code 3, Pending.

4 Not a Case - Use Code 4 for cases where the use of the code is definitely not warranted. This code is used for a referral from another agency or institution that does not contact with the agency for extended evaluation.

5 Benefits Discontinued - Use Code 5 for individuals who were allowed benefits but have since discontinued and who have not subsequently been allowed benefits. If an individual's benefits were discontinued and later reinstated, the status would be reported as Code 1. If an individual's benefits were discontinued and a subsequent application for benefits is pending, he would be reported as Code 3, Applicant Status of Application Pending, since the acceptance of the application was the last official decision.

STREET ADDRESS - BOX OR RURAL ROUTE - Enter the address by street and number, or rural route and box number, so the individual can be located easily.

CITY: Enter the name of the town or city of the individual's mailing address.

COUNTY CODE: Enter the 2-digit code for the county of residence for the applicant. For institutionalized individuals, enter the county of legal residence. Refer to Code Section of Manual.

ZIP CODE: Enter the zip code.

TELEPHONE NUMBER: enter the applicant's telephone number or the number at which the applicant may be reached.

TELEPHONE TYPE: Record voice, Video or TDD.

FEDERAL SPECIAL PROGRAM CODE: Enter the appropriate code from the list of codes below. Add the numbers as appropriate category and enter this sum as the Special Program Code.

Code Definition

000	None or Not known at the Federal special program.	Individual is not identified with any of the categories listed above.
001	Social Security Disability Recipient - The individual is receiving SSDI benefits.	Social Security Disability Recipient (SSDI) - The individual is receiving SSDI benefits.
002	Veteran - The individual was discharged or released from active military service.	Armed Services in active duty and conditions other than dishonorable.
020	Individual referred to the Department of Veterans Affairs as a Post Traumatic Stress Disorder Specialist.	Post Traumatic Stress Disorder Specialist.
040	Brain Injury - An individual who has suffered a traumatic incident resulting in some degree of brain damage.	Brain Injury - An individual who has suffered a traumatic incident resulting in some degree of brain damage.
100	Individual with a significant visual, aural, or physical impairment. Do not include any other condition of the individual. If this condition is not secondary to the individual's condition for the purpose of the program.	Individual with a significant visual, aural, or physical impairment. Do not include any other condition of the individual. If this condition is not secondary to the individual's condition for the purpose of the program.
200	Supplemental Security Income Recipient - the individual is receiving SSI.	Supplemental Security Income Recipient - the individual is receiving SSI.
400	Significantly Disabled - Use this code if at any time during the individual's condition impairment is considered significantly disabling.	Significantly Disabled - Use this code if at any time during the individual's condition impairment is considered significantly disabling.

Examples

- 1) If a case is not in any of the categories listed above, the code 000 must be used.
- 2) If the case is receiving SSDI, the code is for (Significantly Disabled) + 001(SSDI Recipient) = 401.

COMPARABLE BENEFITS: Enter the applicable current comparable benefits 3 - digit code. (Refer to Part 6 on the RS-4 for appropriate code)

DATE OF BIRTH: Enter Year, Month

GENDER: Check appropriate box.

RACE - ETHNICITY: Check appropriate

PREFERRED RACE - ETHNICITY: Fill in

1. White
2. Black/African American
3. American Indian or Alaska Native
4. Asian
5. Native Hawaiian/other Pacific Islander
6. Hispanic or Latino

of race/ethnicity.

REFERRAL SOURCE

referral code from organization or agency if a state or local government referral source. An effort to self-refer.

AND CODE

referral source

enter the 2-digit code for an agency, organization, or individual. For example, 01 for the proper individual. 02 for the individual.

10

- in
- 12 Vocational School (including trade, and other technical)
- 14 Elementary or high school
- 16 School for persons with mental disabilities
- 19 Other educational institution

trade, and other technical

secondary education

Hospitals and Sanatoriums

- 20 Mental Hospital
- 22 Other chronic condition hospital or sanatorium
- 24 General hospital
- 29 Other hospital or clinic

and Private)

hospital or sanatorium

Health Organizations

- 30 Community Rehabilitation Center (except community mental health center)
- 32 Community Mental Health Center
- 34 Children and Family Service
- 38 Other public health department, organization, or agency (including public health nurse or clinic)
- 39 Other private health organization or agency

except community mental health center)

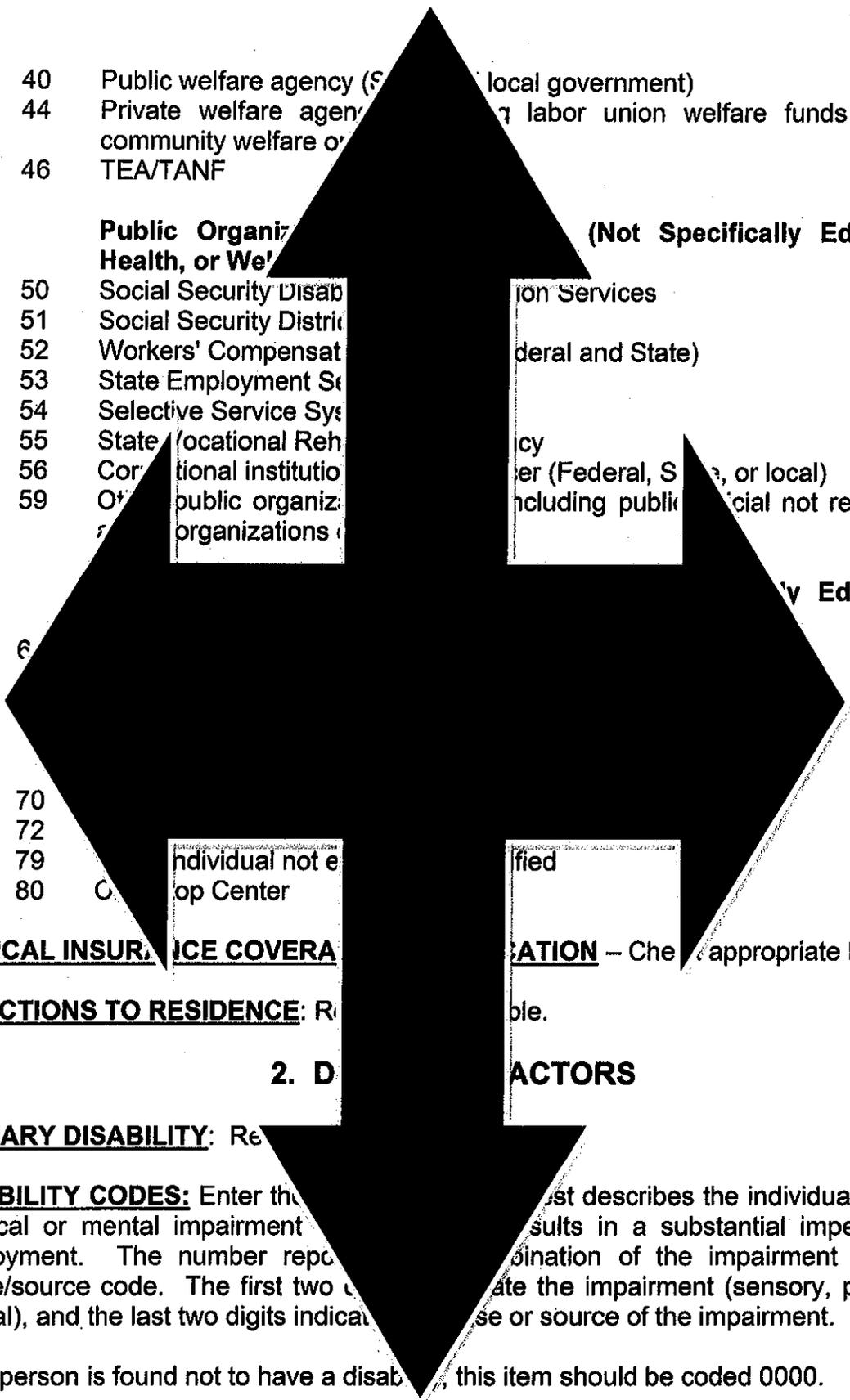
organization, or agency (including public health nurse or clinic)

Welfare Agencies

- 40 Public welfare agency (State or local government)
- 44 Private welfare agency, labor union welfare funds and civic community welfare organizations
- 46 TEA/TANF

Public Organizations (Not Specifically Educational, Health, or Welfare)

- 50 Social Security Disability Services
- 51 Social Security District Office
- 52 Workers' Compensation (Federal and State)
- 53 State Employment Security
- 54 Selective Service System
- 55 State Vocational Rehabilitation Agency
- 56 Correctional institutions (Federal, State, or local)
- 59 Other public organizations including public organizations not representing



6

- 70
- 72
- 79
- 80

Individual not employed
Op Center

ified

MEDICAL INSURANCE COVERAGE – Check appropriate box.

DIRECTIONS TO RESIDENCE: Readable.

2. DISABILITIES

PRIMARY DISABILITY: Readable.

DISABILITY CODES: Enter the code that best describes the individual's primary physical or mental impairment that results in a substantial impediment to employment. The number represents the combination of the impairment code and cause/source code. The first two digits indicate the impairment (sensory, physical or mental), and the last two digits indicate the cause or source of the impairment.

If the person is found not to have a disability, this item should be coded 0000.

CODES FOR IMPAIRMENTS

00 No impairment

SENSORY/COMMUNICATIVE IMPAIRMENTS:

- 01 Blindness
- 02 Other Visual Impairment
- 03 Deafness, Primary Cerebral Visual
- 04 Deafness, Primary Auditory
- 05 Hearing Loss, Primary Visual
- 06 Hearing Loss, Primary Auditory
- 07 Other Hearing Impairment (e.g., Meniere's Disease, hyperacusis, etc.)
- 08 Deaf-Blindness
- 09 Communicative Impairment (expressive/receptive)

PHYSICAL IMPAIRMENTS:

- 10 Mobility Orthopedic/Neurological Impairments
- 11 Manipulation/Dexterity Neurological Impairments
- 12 Both Mobility and Manipulation Orthopedic/Neurological Impairments
- 13 Orthopedic Impairment (limited range of motion)
- 14 Laboratory Impairment
- 15
- 16

MENT

- 17
- 18 processing
- 19 impairments,

CAUSES FOR CA

- 00 Cause unknown
- 01 Accident/Injury (other than CI)
- 02 Alcohol Abuse or Dependence
- 03 Amputations
- 04 Anxiety Disorders
- 05 Arthritis and Rheumatoid Arthritis
- 06 Asthma and other Allergies
- 07 Attention-Deficit/Hyperactivity Disorder (ADHD)
- 08 Autism
- 09 Blood Disorders
- 10 Cancer
- 11 Cardiac and other Circulatory System
- 12 Cerebral Palsy
- 13 Congenital Condition (e.g., Sickle Cell Anemia)
- 14 Cystic Fibrosis
- 15 Depressive and other Mental Disorders
- 16 Diabetes Mellitus
- 17 Digestive
- 18 Drug Abuse or Dependence (other than alcohol)

CAUSES OF IMPAIRMENTS

- CI)
- Circulatory System

- 19 Eating Disorders (e.g., anorexia, bulimia, or compulsive overeating)
- 20 End-Stage Renal Disease and other Genitourinary System Disorders
- 21 Epilepsy
- 22 HIV and AIDS
- 23 Immune Deficiency //AIDS
- 24 Mental Illness (not listed elsewhere)
- 25 Mental Retardation
- 26 Multiple Sclerosis
- 27 Muscular Dystrophy
- 28 Neurological Disorders
- 29 Personality Disorder
- 30 Physical Disorders (not listed elsewhere)
- 31 Polio
- 32 Respiratory Disorders (Cystic Fibrosis or Asthma)
- 33 Schizophrenia and Psychotic Disorders
- 34 Specific Learning Disabilities
- 35 Spinal Cord Injury (Traumatic)
- 36 Stroke
- 37

AGE AT ONSET:

CAUSE:

LAST TREATMENT OR EXAMINATION:

SECONDARY PHYSICIAN:

SECONDARY CAUSE:

ABILITY CODE:

4-digit disability code.

AGE AT ONSET:

Record age at onset.

ability.

CAUSE: Record cause of secondary condition.

LAST TREATMENT OR EXAMINATION:

Record the information requested.

PROSTHESIS USED: Record type of prosthesis used.

Record the information requested.

PRIMARY PHYSICIAN: Record name of primary physician.

Record name.

3. Social Factors

MARITAL STATUS: Check appropriate

HOUSEHOLD MEMBERS-NAME: R...s living in the household.

Date Of Birth – Relationship - Emp... information as requested.

LIVING ARRANGEMENT AT... the living arrangements of the individual, either temporary... of application to the State VR Agency. Enter the 2-digit code from

- 01 Private Residence (independent...ly or other persons)
- 02 Community Residential/Group
- 03 Rehabilitation Facility
- 04 Mental Health Facility
- 05 Nursing Home
- 06 Adult Correctional Facility
- 07 Halfway
- 08 Substance
- 09 Home
- 10 Other

FAMILY

PRIMARY... primary source of support... at application although it n... general rule is that the suppo... related directly to the individual

A common source... error in coding payment to, source... record. For ex... current earnings of her husband or recorded for primary source of su... earnings" or "unemployment insur... combinations of public assistance p... in making the determination. For exa... receives public assistance payments because of his/her disability a... ice as aid to his/her dependent children. The total amount of p... ing both Federal and non-Federal, should be considered as one sir... will be used only when the public assistance is General Assistance e... largest single source of support.

Institutionalized clients will be record... "public institution-tax supported" if they are supported in the institution by public... funds. However, if the person is being maintained in the institution by othe... financial sources such as the family, or hospitalization insurance, or other funds, the appropriate source of the funds will be recorded

Enter the **1-digit** code from the following list of codes:

Code Definition

- 1 Personal Income (earnings, interest, dividends, rent)
- 2 Family and Friends
- 3 Public Support (SSI, SSDI, TANF, etc.)
- 4 All other sources (e.g. private insurance and private charities)

PUBLIC ASSISTANCE AT AGENCY: Record if receiving public assistance from any agency. Enter 1 if receiving and enter the monthly amount; 0 if not receiving. Enter 1 if receiving and enter the monthly amount.

PERSONS THROUGH WHOM I MAY BE CONTACTED: Record the requested information.

MAY BE CONTACTED: Record the requested information.

NAME - ADDRESS - TELEPHONE: Record the requested information.

RELATIONSHIP: Record the requested information.

Note: It is very important this part will be maintained and contact with this person will be maintained.

REMARKS: Record for persons who are not currently completed and whose residence is permanent or otherwise.

HIGHEST LEVEL OF INSTRUCTION: Record the highest level of education completed.

LOCATION: Record the location of the person.

IEP: Record if the person has an Individualized Education Program (IEP).

OTHER TRAINING INSTITUTION: Record the name of the institution.

TYPE OF SCHOOL OR INSTITUTION: Record the type of school or institution.

Record requested information.

5. VOICING: Record if the person is currently employed in a voicing position.

FACTORS: Record the factors affecting the person's employment.

CURRENTLY EMPLOYED: Check if currently employed.

HOURS PER WEEK - PRESENT EMPLOYMENT - WEEKLY EARNINGS: Record requested information.

EMPLOYER NAME - TYPE OF WORK - MONTHS EMPLOYED - DATE LAST EMPLOYED: Record requested information.

EMPLOYMENT INTERRUPTED: Check if employment has been interrupted.

REASON: Record the reason for interruption. If yes, state reason.

PREVIOUS EMPLOYMENT: Record the type of work performed, and length of time employed.

RECENT EMPLOYMENT: Record the type of work performed, and length of time employed.

6. COMPARABLE BENEFITS

COMPARABLE BENEFITS: Record the information and check the appropriate box or boxes.

COMPARABLE BENEFITS CODE: Record the comparable benefit code, add the numbers assigned to each of the codes, and record the total comparable benefits code.

MIGRANT AND SEASONAL FARM

check appropriate box.

7.

ON

List the services and vendors requested.

icant.

APPLICANT'S SIGNATURE AND DATE: Record the applicant's signature and date of application.

Record the applicant's or representative's signature.

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: _____ Text Only? _____
Work: _____
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? _____

Contacts:

Last Name: _____ First Name: _____

Title: _____

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?

When did you work last? _____

Why aren't you working now? _____

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: _____

For Office Use Only:

Target Group: _____

Referral Source: _____

Referral Received Date: _____

STATE OF ARKANSAS



Mike Beebe
Governor

Bill Walker
Director

Arkansas Career Education
Division of Rehabilitation Services

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

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 THE:

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: _____

DOB: _____

Home Telephone: _____

Gender: _____

Street: _____

Suite/Apt #: _____

Zip: _____

City: _____

State: _____

County: _____

Email: _____

Referral Received Date: _____

Referral Source:

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

Living Arrangement:

Employment at Application:

Is Client Working? N

Work Status:

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 for Aged
- SSI for Disabled
- Temporary Assistance for Needy Families (TANF)
- General Assistance (State or Local Government) NOT FEDERAL
- Social Security Disability Insurance (SSDI)
- Veterans' 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? _____

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? _____

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: _____

Monthly 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?

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:

Monthly 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?

If Used:

CRP Vendor:

ACTI:

Type of ACTI services provided:

Complete?

Health Insurance?

Paid Leave?

Paid Life Insurance?

Employer Pays All Medical?

Education 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: _____

Services Provided By School: _____

Contacts At This School:

Last Name: _____ First Name: _____

Title: _____

College and Vocational Education

Dates attended: _____ through _____

School's Name: _____

Major/Field of Study: _____

Certification/Degree: _____

Date Obtained: _____

Vocational Training: _____

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

Other Certifications:

Other Skills By Self Report

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

Other Skills:

**ARKANSAS REHABILITATION SERVICES
CASE NARRATIVE**

Last Name:

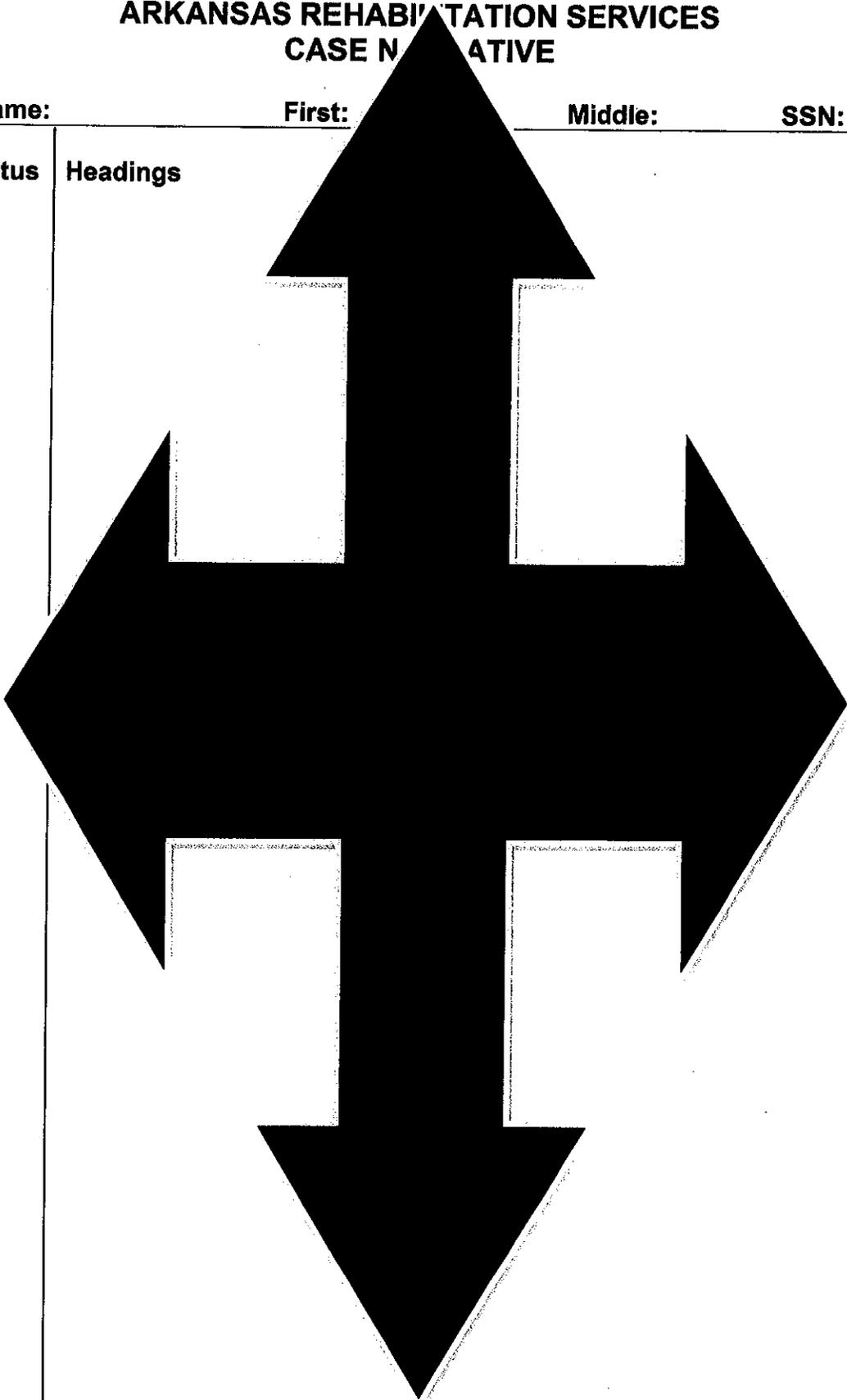
First:

Middle:

SSN:

Date & Status

Headings



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, and headings for referral and acceptance/plan development. ~~This form is self-explanatory. are included.~~

ARKANSAS REHABILITATION SERVICES AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____ Birth Date _____ Social Security Number _____

1. I hereby authorize use or disclosure of personal information about me as described below.
2. The following individual/institution or organization is authorized to make the disclosure:

3. This information may be disclosed to the following individual or organization:

Attn. Of: **Arkansas Rehabilitation Services**

Counselor _____

Address _____

- for the purpose of Establish eligibility
 Develop a vocational plan
 Determine need for services
 Other (specify) _____

Arkansas Rehabilitation Services
 Individual
 Treatment

The specific information includes:

- History
- Diagnosis
- Other
- Treatment
- Current
- Vocational
- Other

4. I understand that this information may be used for the diagnosis, treatment, or management of a disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about my behavior or activities, and treatment for alcohol and drug abuse.
5. I understand I have the right to revoke this authorization I may do so in writing and apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will expire 12 months following the date signed by me.
6. I understand that authorizing the disclosure of information carries with it the potential for release of information that is not protected by federal confidentiality rules (HIPAA). I understand any disclosure of information is voluntary. I understand any disclosure of information and the information may not be protected by federal confidentiality rules (HIPAA).

7. Health information may be faxed to the following individual or organization (please provide appropriate space)

8. An electronic copy of the authorization is being provided to the following individual or organization (please provide appropriate space) _____ original.

THIS FORM MUST BE COMPLETED BEFORE SIGNING

Signature of Individual/Representative

Date

Relationship to Individual if signed by Representative

Signature of Witness

AUTHORIZATION FOR RELEASE OF INFORMATION INSTRUCTIONS (M-6)

This form is to be used when requesting information or exchange of information from another agency or vendor.

1. Client Name: Self-explanatory.
2. Birth date: Self-explanatory.
3. Authorize: Record hospital, clinic, a
bl.
4. Name or title of person(s) or organi:
explanatory. disclosure is to be made: Self-
5. Specific Type of Information to be E
k appropriate l (s).
6. The Purpose r ed for Such Di
k appropriate t
7. Client Sign required.
authoriz
signat' Individual is
or an
dian
8. Witness.



W-29B (Rev 5/08)

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:

for 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 records**
- 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.

** **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by 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 is 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 state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524

RIDAC SERVICE AUTHORIZATION

NAME _____ COUNSELOR _____
 (Last) (Name) No.
 SSN _____ D.O.B. _____ DATE OF RIDAC APPT. _____
 DISABILITY _____ DISABILITY CODE _____
 EDUCATIONAL LEVEL _____ VOC. INTEREST _____

SERVICE REQUESTED

ASS

PROBLEMS OR QUESTIONS TO BE ADDRESSED

GENERAL MEDICAL
 CONSULTATION/GM

MENTAL HEALTH
 CONSULTATION

PSYCHOLOGICAL
 CONSULTATION

IND. VOC.

COUNSELOR

- ____ Client reported _____ problems.
- ____ Client reported _____
- ____ Client reported a history of _____ or Mental Health _____ without _____ assessment/treatment
- ____ Client reported a history of _____ records available _____ unavailable _____ (with _____ without _____ assessment)
- ____ Client reported a history of _____ of Special Ed. (_____ unavailable _____) _____ placement
- ____ Client reported a history of _____ of sheltered work _____
- ____ Client unable to Read/Write _____
- ____ Client reported a history of Head Injury _____
- ____ Client reported a history of Legal Problem _____
- ____ Client reported a history of _____ Vision _____ Problems
- ____ Accommodations required _____

[Please request clients bring a list of medications _____ (or to be) taken to the RIDAC Evaluation. Also, request clients bring prescription eye wear _____, _____ or hearing aids to the evaluation.]

COUNSELOR SIGNATURE _____ COUNSELOR NO. _____ DATE _____

~~RIDAC SERVICE AUTHORIZATION FORM INSTRUCTIONS~~

~~This authorization for RIDAC services is to be completed and signed by the counselor prior to scheduling an individual for RIDAC services. The form is self-explanatory. The counselor will identify needed assessment services.~~

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

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

[@ServiceNameLabel]:

Service Detail:

[@ServiceNameLabel]:

Service Detail:

[@ServiceNameLabel]:

Service Detail:

SIGNATURE

Date

SIGNATURE

Date

ARKANSAS REHABILITATION SERVICES GENERAL MEDICAL ASSESSMENT

Counselor Name _____ Counselor # _____ Location _____

To Be Completed by _____ Counselor

Name _____ Birth date _____

Primary Physician Name _____ Location _____

INDIVIDUAL'S DESCRIPTION OF DISABILITY:

COUNSELOR OBSERVATIONS:

TO BE COMPLETED BY PHYSICIAN (FRONT AND BACK)
PRIMARY DISABLING CONDITION

CHARACTERISTICS OF DISABILITY:

Permanent
Slightly

MAJOR DISABLING CONDITION:

Relatively
Substantially

SECONDARY (AND OTHER) DISABLING CONDITIONS:

PHYSICAL CAPACITIES: (Use "PHYSICAL ACTIVITIES" AND "WORKING CONDITIONS")

BOLE(S) (X) LIMITING CONDITION

TO BE AVOIDED AND APPROPRIATE UNDER

PHYSICAL ACTIVITIES: Walk Stand
Kneeling Lifting Reaching
Other (specify) _____

Working Being Pulled
Pushing Pulling

WORKING CONDITIONS: Outside Inside Humid
Other (specify) _____

Dusty Temperature Extremes

DEFICITS IN FUNCTIONAL CAPACITY AREAS: (check appropriate)

(Term description on back)

Mobility Communication
Interpersonal Skills Work Tolerance

RECOMMENDATIONS: (Indicate as Appropriate)

SPECIALIST EXAMINATION ADVISABLE FOR _____ DIAGNOSIS OR
PROGNOSIS (SPECIFY TYPE) _____
TREATMENT (SPECIFY TYPE AND APPROXIMATE DURATION) _____

OTHER _____

**ARKANSAS REHABILITATION SERVICES
GENERAL MEDICAL ASSESSMENT**

REMARKS:

HISTORY AND PHYSICAL

DESCRIPTION OF PROBLEM

HEENT

VISION

No

HEARING

No

LUNGS

No

HEART (BP _____)

ORTHOPEDIC

NEUROLOGICAL

OTHER

No

PHYSICIAN'S SIGNATURE

DATE

DEFINITION OF FUNCTIONAL

MOBILITY – Capability of moving efficiently from place to place.

COMMUNICATION – Accurate and efficient transmission of information.

SELF-CARE – Ability to fulfill basic needs such as grooming, transportation, housing, homemaking, and medication management.

SELF-DIRECTION – Capacity to organize, structure, and manage one's own life.

INTERPERSONAL SKILLS – Ability of the individual to interact with others in an acceptable and mature manner with coworkers, supervisors and others to facilitate the normal work process.

WORK TOLERANCE – Ability to carry out required work tasks in an efficient and effective manner over a sustained period of time.

WORK SKILLS – Those specific skills required to carry out work tasks as well as the capacity for an individual to benefit from training in those work functions.

ACTIVITY AREAS

of either verbal or non-verbal information. health, safety, food preparation and nutrition,

in a manner which best served the objectives

acceptable and mature manner with co-

work tasks in an efficient and effective

as well as the capacity for an individual to

ARKANSAS REHABILITATION SERVICES

GENERAL MEDICAL ASSESSMENT

Counselor Name

Counselor #

Location

To Be Completed by Counselor

Client's Name

Birth Date

Primary Physician

Name

Location

CLIENT DESCRIPTION OF DISABILITY:

[Dashed box for client description of disability]

COUNSELOR OBSERVATIONS:

[Dashed box for counselor observations]

TO BE COMPLETED BY PHYSICIAN (FRONT AND BACK)

PRIMARY DISABLING CONDITON:

[Dashed box for primary disabling condition]

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 CONDITIONS:

PHYSICAL CAPACITIES

Physical Activities:

Limitations To be Avoided

Working Conditions:

Limitation To be Avoided

Walking	<input type="checkbox"/>	<input type="checkbox"/>	Outside	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	Inside	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	Humid	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	Dry	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	Dusty	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	Temperature Extremes	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	Dangerous Machinery	<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"/>			
Strenuous labor	<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 (BP ____/____)

No Yes

ORTHOPEDIC

No Yes

NEUROLOGICAL /MENTAL STATUS No Yes

OTHER:

PHYSICIAN SIGNATURE

DATE

CLIENT'S NAME:

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

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

ARKANSAS REHABILITATION SERVICES MEDICAL CONSULTANT WORK SHEET

Client _____ Date _____

Vocational Objective _____

		No	Recommendation	Date of Re-evaluation
I.	Diagnosis			
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 special consultation indicated?			
	3. Is hospitalization for diagnosis indicated?			
	4. Is _____			
II.				
A.				
B.	Can _____ or _____ in a _____			
III.	Rehabilitation Plan			
A.	Is treatment plan satisfactory?			
B.	Is training plan satisfactory From a physical standpoint?			
C.	Is placement plan satisfactory From a physical standpoint?			

Comments: (If more space is needed for comments, continue using back of this sheet if necessary.)

M.D.
Medical Consultant

MEDICAL CONSULTANT WORKSHEET (RS-3G) INSTRUCTIONS

Self-explanatory. The counselor will complete the top section of the form.

**ARKANSAS REHABILITATION SERVICES
MEDICAL CONSULTANT WORKSHEET**

CLIENT: Date:

Counselor: Counselor# Location:

Vocational Objective:

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

B. Is Training plan satisfactory from a physical standpoint?				
C. Is Placement plan satisfactory from a physical standpoint?				

[Redacted Signature]

M.D

Client:

[Redacted Client Name]

ARKANSAS REHABILITATION SERVICES PHYSICIAN CONSULTANT WORKSHEET

(This confidential report is generated for Arkansas Rehabilitation Services use only. Available treating physician reports were reviewed to complete this document. Information contained in this report should not be utilized for the purpose of treatment or the Determination of eligibility for other public or private programs.)

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

Working Conditions:

Limitation

To be Avoided

Walking

Outside

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"/>
Repetitive Use of Hands	<input type="checkbox"/>	<input type="checkbox"/>
Strenuous labor	<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 Noise	<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 STATEMENT OF UNDERSTANDING INSTRUCTIONS

~~This form is to be completed on all gastric bypass cases and is to be signed by the individual and placed in the record of service.~~

GASTRIC BYPASS SURGERY CHECKLIST
Required information for submission to the District Manager

Client's Name: _____ SSN: _____

	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"/>
Co-Morbid Conditions:		
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:

GASTRIC BYPASS CHECKLIST INSTRUCTIONS

~~Form completion is self-explanatory.~~

Arkansas Department of Career Education
Arkansas Rehabilitation Services
#26 Corporate Hill 525 W. Capitol
Little Rock, AR 72205 I
Phone/TTY (501) 683-0719 or Toll Free/TTY 800-828-2799 or fax (501) 666-5319
AT @ Work Referral Form

Date:

To: AT @ Work Team Fax 501-686-2831 666-5319

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.

The counselor will also be responsible for obtaining the consumer's signature on the retention of title for necessary equipment.

ARKANSAS REHABILITATION SERVICES CERTIFICATE OF INELIGIBILITY

CLIENT NAME

CASE NUMBER

The diagnostic study has been completed based on the information I have and to the best of my knowledge and judgment that you are eligible for vocational rehabilitation services. If you are dissatisfied with this decision, you may file a request for an administrative review of this decision with one member or members of the supervisory staff of the agency. If dissatisfied with the findings of this review, you will be given an opportunity for a fair hearing. You may be afforded an annual review to determine if any changes have occurred which would result in a decision of eligibility.

THE REASON(S) FOR THIS DECISION IS:

DESCRIBE CLIENT

DATE FOR ANNUAL REVIEW

CLIENT SIGNATURE

DATE

SIGNATURE

NUM

DATE

ARKANSAS REHABILITATION SERVICES CERTIFICATE OF ELIGIBILITY

NAME: _____
(LAST) (F) MI SOCIAL SECURITY NUMBER

IN ACCORDANCE WITH THE REHABILITATION ACT OF _____ ENDED, IT IS DETERMINED THAT THE ABOVE NAMED INDIVIDUAL IS AN INDIVIDUAL WHO:

(1) HAS A PHYSICAL OR MENTAL IMPAIRMENT

WHICH CAUSES LIMITATIONS OF

AND CON.

(2) A. IT IS NECESSARY FOR THE INDIVIDUAL TO RECEIVE REHABILITATION SERVICES IN TERMS OF _____ DETERMINE IF VOCATIONAL REHABILITATION SERVICES WILL BENEFIT THE INDIVIDUAL

REHABILITATION SERVICES:

COUNSELOR NAME

COUNSELOR SIGNATURE

NO.

DATE

B. CAN BENEFIT IN TERMS OF AN EMPLOYMENT OPPORTUNITY FROM VOCATIONAL REHABILITATION SERVICES

REHABILITATION SERVICES:

COUNSELOR NAME

COUNSELOR SIGNATURE

NO.

DATE

THE INDIVIDUAL REQUIRES VOCATIONAL REHABILITATION SERVICES TO PREPARE FOR, ENTER, ENGAGE IN, OR RETAIN GAINFUL, EMPLOYMENT

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

- Limitations :

[Empty rectangular box]

- Self Care
 - Limitations :

[Empty rectangular box]

- Self Direction
 - Limitations :

[Empty rectangular box]

- Work Skills
 - Limitations :

[Empty rectangular box]

- Work Tolerance
 - Limitations :

[Empty rectangular box]

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

[Empty rectangular box]

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: _____

Extended Evaluation 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 (RS-600-B-1)

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 impairment 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 ~~must be printed~~ is attached ~~and placed to~~ in the case folder ECF.

CERTIFICATE OF INELIGIBILITY INSTRUCTIONS (RS-4C)

1. The Certificate of Ineligibility, ~~RS-4c~~, 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, ~~in duplicate and the original is provided~~ a copy to the applicant and a copy is placed attached to in the local ECF.
9. ~~The individual should manually sign and record the date of signature~~
10. ~~The counselor signs, record counselor number, and date of signature.~~

STATE OF ARKANSAS

Mike Beebe
Governor

Bill Walker
Director



Arkansas Career Education
Division of Rehabilitation Services
Randy Lavery, Commissioner

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ILRS Certificate of Eligibility/Ineligibility

Name: _____

Case Number: __

Counselor: _____

Signed Date: _____

- The limitations 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 INSTRUCTIONS (RS-600-B-1)

1. The Certificate of Eligibility for ILRS is generated by the case management system after Status 72 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 printed and placed attached to in the ECF case folder.
5. The physical or mental impairment disability, the limitations, and the date of certification are to be keyed.

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 5th 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

This individual meets the criteria for Priority for Services:

Status 10

Status 04

Category

I II III

(Please check appropriate box)

Counselor Signature

Counselor #

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.

- ~~1. The counselor will record the individual's name, Social Security Number, and check Yes or No for question #1.~~
- ~~2. The counselor will complete the Assessment for Determining Priority Category for Services. Utilizing the information below, the counselor will determine the Priority Category.~~
- ~~3. The counselor will check Yes or No if multiple services over an extended period of time are necessary.~~
- ~~4. The counselor will select the placement of Priority for Services by checking Category I, II, or III.~~
- ~~5. If the placement category is I or II, the counselor will check Status 10.~~
- ~~6. If the placement category is III the individual will be given the option of being placed on a waiting list for services (Status 04) or closed Status 30. If the individual chooses placement on the waiting list, the counselor will check Status 04.~~
- ~~7. The counselor will sign and date the form.~~

ORDER OF SELECTION

Under the Vocational Rehabilitation Act (Title IV of the Workforce Investment Act of 1998) certain state Vocational Rehabilitation agencies are required to have an order of selection. An order of selection requires that a priority be given to individuals with the most significant disabilities in the provision of vocational rehabilitation services. The order of selection is required in the event that the state is unable to provide the full range of vocational rehabilitation services to all eligible individuals or, in the event that vocational rehabilitation services cannot be provided to all eligible individuals in the

~~State who apply for the services. ARS has determined that there are insufficient funds to provide services to all eligible individuals within the State.~~

~~The ARS Order of Selection assures the highest priority in service provision is reserved for eligible individuals with the most significant disabilities. Services and expenditures are closely monitored to enable the ARS Commissioner to close or open priority categories as deemed appropriate. This will assure services are continued for cases determined eligible and receiving services under an Individualized Plan for Employment. Adequate funds will be reserved to provide diagnostic services for all applicants to determine eligibility and category placement.~~

DESCRIPTION OF PRIORITY SELECTION

~~The Order of Selection priority categories, justification for each, outcome and service goals are listed below:~~

~~ARS will provide services based on an Order of Selection on a statewide basis. The ARS Order of Selection assures clients in Priority I and II will have first priority for the provision of services. If funds become available, individuals in Priority III may receive services.~~

~~Rehabilitation clients who have an Individualized Plan for Employment (IPE) for vocational rehabilitation (VR) services or extended evaluation (EE) services in place prior to the implementation of the Order of Selection policy will receive services as recorded in their IPE.~~

Priority Category I – Most Significantly Disabled

~~An eligible individual with a most significant disability is defined as one who has a significant physical or mental impairment which:~~

- ~~1) Seriously limits at least three functional capabilities (mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employment outcome;~~
- ~~2) Whose vocational rehabilitation can be expected to require multiple VR services* over an extended period of time**; and~~
- ~~3) Who has one or more physical or mental disabilities as defined below***.~~

Priority Category II – Significantly Disabled

~~An eligible individual with a significant disability is defined as one who has a significant physical or mental impairment which:~~

- ~~1) Seriously limits two functional capacity area (mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employment outcome;~~
- ~~2) Whose vocational rehabilitation can be expected to require multiple VR services* over an extended period of time**; and~~

~~3) Who has one or more physical or mental disabilities as defined below***.~~

Priority Category III – Non-Significantly Disabled

~~An eligible individual with a non-significant disability is defined as one who has a significant physical or mental impairment which:~~

~~1) Seriously limits one functional capacity area (mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employment outcome;~~

~~2) Whose vocational rehabilitation can be expected to require multiple VR services* over an extended period of time**; and~~

~~3) Who has one or more physical or mental disabilities as defined below***.~~

~~Definitions:~~

~~* Two (2) or more major VR services, i.e. counseling, guidance, assistive technology, physical or mental restoration, training, and placement.~~

~~** 90 days or more from the date services are initiated.~~

~~*** One or more physical or mental disabilities resulting from: amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders (including stroke and epilepsy), spinal cord conditions (including paraplegia and quadriplegia), sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs to cause comparable substantial functional limitation.~~

PRIORITY OF CATEGORIES TO RECEIVE VR SERVICES UNDER THE ORDER OF SELECTION

~~ARS will provide services based on an Order of Selection on a statewide basis. The ARS Order of Selection assures clients in Priority I and II will have first priority for the provision of services. If funds become available, individuals in Priority III may receive services. Rehabilitation clients who have an Individualized Plan for Employment (IPE) for vocational rehabilitation (VR) services or extended evaluation (EE) services in place prior to the implementation of the Order of Selection policy will receive services as recorded in their IPE.~~

STATE OF ARKANSAS



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Division of Rehabilitation Services
Randy Lavery, Commissioner

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An Equal Opportunity Employer

Dear _____:

When you applied for Rehabilitation Services, I explained the 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:

┌

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

If you are listed in Category III or IV, you must choose (check one)

- Assistance with referral to other workforce investment programs/benefits
- To be placed on 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

~~ORDER OF SELECTION NOTIFICATION LETTER INSTRUCTIONS~~

- ~~1. The counselor will check the appropriate category.~~
- ~~2. The form will be mailed to the client and a copy placed in the file.~~

**ARKANSAS REHABILITATION SERVICES
FINANCIAL RESOURCES**

Name of Client _____
(Last) (First) (MI)

Date _____ Total Number In Household _____

I. CAPITAL ASSETS

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

V. COMPARABLE BENEFITS

	Yes	No	Amount**
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	\$
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	\$
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	\$
Disability (e.g. Only)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	\$
TOTAL (Lines 22 - 28)			\$

II. MONTHLY INCOME

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 (Monthly)	\$
11. TANF (Client)	\$
12. Other (Include)	\$
13. TOTAL	\$

III.

14. Family	\$
15. Special C	\$
16. Special Condi	\$
17. TOTAL (Lines 14-16)	\$

IV. CLIENT'S AVAILABLE RESOURCES

(Do not complete for SSI/SSDI Recipients)

18. Monthly Income Available (Line 17 minus Line 13, if a negative amount enter 0.)	\$
19. Income Available (Line 18 times number of months)	\$
20. Capital Assets (Line 3)	\$
21. TOTAL (Lines 19 & 20)	\$

I hereby certify that all information in Sections I through IV is true and correct to the best of my knowledge. I also grant permission for the Arkansas Rehabilitation Services to investigate the accuracy of this report. If you have any changes, I agree to notify the Counselor.

Client Signature _____

Counselor Signature _____

**Estimate if exact amount is not available.

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. ~~A properly executed~~ The RS-16 must be included in the case record ECF of each individual prior to the provision of any services. ~~based on financial need.~~ **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 comparable benefits.** ~~The RS-600-A and RS-600-C~~ The IPE and IPE Amendments are used to summarize and compute the amount of supplementation necessary. 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 is cash on hand, saving and checking accounts, bonds, securities, and other negotiable papers that can readily be turned into cash. ~~will be interpreted as meaning cash and those instruments~~ 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.

Number of Persons	Monthly Amount
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 essential purpose of providing the Comparable Benefits Section is to establish a way to document that a search for comparable benefits has been made. It should also be a tool in helping deal with financial planning. This list will provide a checklist of some of the well-known financial resources counselors will use as comparable benefits. The counselor must advise the individual where to go and who to call for each source of comparable benefits and monitor the search.~~

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 individual and counselor will manually sign in the appropriate space. The electronic date and signatures of the individual and the counselor indicate understanding of, and agreement.~~

INDIVIDUALIZED PLAN FOR EMPLOYMENTS (RS-600-A)

1. Enter last name, first name and middle initial. Add individual's Social Security #.
2. Check appropriate box.
3. (A) A vocational goal must be listed with its classification. (B) Add the six-digit SOC code. (C) Enter appropriate starting salary for the goal selected. (D) Enter appropriate box. (E) Add appropriate item should reflect the starting salary for the goal selected. (F) Check appropriate box.

4. This section is for describing the steps toward the achievement of the employment objectives) to be used to evaluate the progress toward the achievement of the employment objectives. (intermediate rehabilitation objectives)

5. For services listed, check appropriate box and write in the name of the service provider. For services not listed, check appropriate box. Enter the month and year the service was provided. Enter the name of the service provider. Method to provide service; check appropriate box.

Explanation:

- Purch
- Prov
- Arr

Cost Estimation:

Student Financial Aid benefits column. Enter the amount of income tax benefits column. Enter the amount of income tax benefits column. (Cost estimation cannot be for more than one year.)

As much as possible, the amount of income tax benefits column. Enter the amount of income tax benefits column. (Cost estimation cannot be for more than one year.)

6. Check appropriate box.
7. Write in date for annual review.
8. Have individual sign and date, the name of the counselor and counselor number. Individual sign and date and list counselor name and number.
9. Provide a copy to the individual.

ARKANSAS REHABILITATION SERVICES INDIVIDUALIZED PLAN FOR EMPLOYMENT AMENDMENTS

1. _____
 (LAST NAME) (FIRST NAME) (MIDDLE) SOCIAL SECURITY NUMBER

2. VR SERVICES TRIAL WORK EXPERIENCES/EVALUATION INDEPENDENT LIVING SERVICES

3. SPECIFIC EMPLOYMENT OUTCOME/IL GOAL: _____ SOC CODE _____

SERVICE INITIATION DATE: _____ ANTICIPATED COMPLETION DATE: _____

ESTIMATED STARTING SALARY: _____ INDIVIDUAL WILLING TO RELOCATE? YES NO

PROJECTED JOB DEMAND: HIGH MODERATE

4. CRITERIA FOR EVALUATION OF PROGRESS TOWARD INTERMEDIATE OBJECTIVES

5. THE INDIVIDUAL'S EMPLOYMENT METHOD TO BE USED TO ACHIEVE THE SERVICE PROVIDERS.

			COST ESTIMATE	
Add	Delete	SERVIC.	Cost	Comparable
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

6. **TERMINATION OF CASE**
- 08 INELIGIBLE FROM 06
 - 26 REHABILITATED
 - 28 INELIGIBLE FROM 14-24
 - 30 INELIGIBLE FROM 10-12
 - 32 POST-EMPLOYMENT
 - 38 SERVICES DELAYED FROM 04
 - 73 IL SERVICES NOT COMPLETE
 - 74 IL SERVICES COMPLETE

7. A. POSITIVE TERMINATION

- B. POST-EMPLOYMENT SERVICES PROVIDED
- DIAGNOSTIC & EVALUATION
 - RESTORATION (PHYSICAL/MENTAL)
 - TRANSPORTATION
 - COUNSELING & GUIDANCE ONLY
 - PLACEMENT
 - MAINTENANCE
 - TRAINING
 - OTHER

8. ANNUAL REVIEW PERIODIC REVIEW TERMINATION
 CHANGE SPECIFIC EMPLOYMENT OUTCOME

JUSTIFICATION / JUSTIFICATION:

The form features a large, central black arrow that points both upwards and downwards. The arrow is composed of a solid black shape with a white outline. Inside the arrow, there are four rectangular white boxes arranged in a 2x2 grid. The top two boxes are positioned within the upper-pointing arrow, and the bottom two boxes are within the lower-pointing arrow. These boxes are intended for providing justification for the employment outcome selected in the list above. The text 'JUSTIFICATION / JUSTIFICATION:' is centered above the top two boxes.

IPE AMENDMENT (FORM RS600-A) INSTRUCTIONS

The RS600-C IPE AMENDMENT is a case form for use in amending the initial IPE whenever a change in the rehabilitation program is needed and to record the progress of the individual's rehabilitation program. A narrative should be made in the case narrative to explain the need for an amendment, which should be consistent with informed choice. The justification for the amendment should be made on the RS600-C IPE AMENDMENT. The counselor should list the items needed to accomplish the amendment or annual review. Items may include a vocational objective change, deletion or addition of a goal, termination of the case, extension of an expired IPE, etc, and the counselor and individual must sign and date the RS600-C IPE AMENDMENT. A copy of the IPE AMENDMENT must be provided to the individual.

The counselor will complete only the following sections:

Complete all sections of the IPE AMENDMENT

1. Enter last name, first name and middle initial.
2. Check appropriate box.
3. If a vocational goal change is required, enter the new goal.

(b) needed to amend the IPE.

Electronic case management system.

Individual's Social Security #.

The job classification

the six-digit code for the

ward

enter service

phased – ARS will be provided – ARS will be provided – Service will be provided

Cost Estimate (a) Enter cost of program (b) Enter cost of services (c) Enter total cost of services (d) Enter difference of services column (e) The difference of services column (f) At this point the counselor should discuss the individual's contribution, the agency contribution, and the total cost. Cost estimates cannot be for more than one year.

other source.

Enter comparable benefits such as Pell Grant, etc. Enter all of comparable benefits column. Unmet needs will be entered in "unmet needs" column. Discuss with the individual the amount of unmet needs and enter the amounts. Cost estimates cannot be for more than one year.

6. Termination of case – Check appropriate box.
7. (A) Post-employment Termination Services Provided – Check appropriate box. (B) Post-employment Services Provided – Check appropriate box.
8. Justification – Check appropriate box.
9. Have individual sign and date, and list counselor number.
10. Provide a copy to the individual.

(B) Post-employment Services Provided – Check appropriate box.

Justification.

and date and list counselor number.

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

IPE

Name: _____

SSN: _____

Date of Birth: _____

Plan Number: _____

Type of Plan: _____

Employment Goal:

Plan begins on _____ and is estimated to end on _____

Annual Review Date: _____

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 of 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 of 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 of 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 EMPLOYMENTS 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.

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

Name: _____
(Last, First, MI) _____ Social Security Number _____

Date: _____

Received of the Rehabilitation Service _____ing property: i.e. durable medical
equipment, educational tools, occupational _____(etc):

Receipt of the items listed above is her
property has been supplied for the
keep such property in good condition at
and recognizes that the right and title to
in the Rehabilitation Service
that this property is
title is released
property is
returned to

_____ed, and it is understood that such
of the undersigned, who agrees to
inspection at reasonable times,
al tools and/or _____ment is vested
understood
of until
used, the
shall be

RECEIVED

Signature of Counselor

No. _____

Signature of Individual

RELEASED

Signature of Counselor

No. _____

Signature of Individual

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

Name: _____ SSN: _____

Date: _____

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

Receipt of 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: Signature of Individual

RECEIPT/RELEASE FOR OCCUPATIONAL TOOLS AND/OR EQUIPMENT AND TITLE AGREEMENT INSTRUCTIONS (M-33)

This form will be prepared in duplicate; the original will be placed attached to in the case record ECF and the a copy provided to the individual.

Complete all sections in the electronic case management system.

1. ~~In the space provided~~ 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. ~~Signature of Individual: The individual will manually sign showing the same name carried in the case record.~~
4. ~~Signature of Counselor: The counselor will manually sign and date.~~

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 _____ Field Counselor _____ No.. _____
Primary Disability _____ Disability Code _____
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 me and/or my disability to prospective employers. Yes No

Signature _____ Date _____

Employment plans

Employment Services Representative 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 ~~Employment Services Representative~~ Business Relations Representative file.

EMPLOYMENT SERVICES REFERRAL FORM INSTRUCTIONS

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

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

Distribution (Field Office)

- Copy of the referral form is attached to in the ECF ~~retained by counselor at referral~~.
- A copy of the referral form remains in the file of the ~~Employment Services Representative~~. Business Relations Representative
- After the client interviews for possible employment, the ~~Employment Services Representative~~ Business Relations Representative completes the form and a copy of this form is ~~retained~~ attached to in the counselor 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 ~~Employment Services Representative~~. Business Relations Representative.
- After the clients interview for possible employment, the ~~Employment Services Representative~~ 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.

REQUEST FOR ACTI/HSRCH SERVICES

CLIENT DATA

Name: _____ SSN: _____ STATUS: _____
 Referring Counselor: _____ Field Office: _____
 Counselor#: _____ Program Code: _____
 Primary / Secondary Disabilities / Age / Date of Onset of Disability (include Code #s): _____
 Describe Status of Disability, If Applicable: _____
 Has Client Been Served at ACTI/HSRCH Before? Yes _____ No _____
 If client has medical or private insurance please attach _____ 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; and check _____
 In order of Priority, list services you need us to provide _____

- (1) _____
- (2) _____
- (3) _____
- (4) _____

(Use back of page if needed)

Vocational Services Requested

- Vocational Evaluation
- Employment Readiness
- Vocational Training
- Other Specify _____

Medical Services Requested

- Medical Eval. Therapy
- Clinics; Ortho. Amp.
- Wheelchair
- Gait / Limb Training
- Limb Maker
- Immunization Record
- Other Specify (Neuropsych / Vision / Hearing / Psychological / Psychiatric) _____

Client Information

- Resident
- Non-Resident
- Worker
- Other _____
- _____ally

Product Standard / Resource

Counselor Signature _____

Date _____

Request for HSRC/ACTI Services

Name: _____

Date of Birth: _____

SSN: _____

Employment Goal:

Date this job goal will be achieved: _____

Field Office: _____

Referring Counselor: _____

Counselor #: _____

Primary 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

Resident Information

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

RIDAC

Immunization Records

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 (RS-344)

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. ~~**Status:** Current Rehabilitation status code (numerical).~~
4. **Referring Counselor:** Record last name only.
5. **Counselor Number:** Record field counselor's number.
6. ~~**Program Code:** Record funding program code number.~~
7. **Primary and Secondary Disabilities:** List primary and all secondary disabilities with codes for each.
8. **Describe Status of Disability:** Complete if applicable. **Example:** Seizure disorder controlled by medication.
9. **Prior ACTI/HSRCH Services:** Dates of previous admissions and services received if known.
10. **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.
11. **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.

12. **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 manually sign and record the date the form is completed.

ARKANSAS REHABILITATION SERVICES
AUTHORIZATION FOR ADJUSTMENT/EXTENDED SERVICES DAYS/
90-DAY CLOSURE (RS-315)

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 "block-funded" CRP, ~~and for an individual to receive or additional training days work adjustment in 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 ~~decide upon the need for the individual to receive services in each instance and complete the RS-315 for either Work Adjustment, or Extended Services Days or 90-Day (Job Placement) Closure Service as appropriate. (if extended services, specify number of months). Service time frames and fees are set out in a contract with a Community Rehabilitation Program and funded under Title XX SSBG. funding for up to 9 months.~~

- ~~1. The RS-315 will be prepared in triplicate for either Work Adjustment, or Extended Services.~~
- ~~2. In each instance, the original and a one copy are submitted to the CRP and one copy will be filed in the record of services.~~
- ~~3. It will be the responsibility of the CRP to forward a copy to the Community Program Development Section.~~

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 ~~original report is signed by the individual and the counselor and to be filed attached to in~~ the ~~case folder~~ ECF and a copy is provided to the individual.

- ~~Self-explanatory~~
- ~~The counselor and individual will sign and date the form.~~
- ~~The original is filed in the case folder and a copy 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.

ARKANSAS REHABILITATION SERVICES RESPONSIBILITIES OF COLLEGE STUDENTS (M-43)

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

- A. You will be expected to apply for assistance on an annual basis and provide copies of the results to this office.
- B. Reports to your counselor:

Name	
Address	

1. Immediately after enrollment report the following:
 - a. Credit hours for each class
 - b. Tuition and dormitory charges
 - c. Progress of school in each semester
2. If final grades are not available, you will be able to use interim grades for your reports.
3. If final grades are not available, you will be able to use interim grades for your reports.

The reports above will be required each semester or term.

- C. Other responsibilities:
 1. It is required that each full-time student maintain a minimum load of 12 semester hours. Enrollment in less than 12 hours is permissible only upon special written permission from your counselor prior to the start of the semester. You will be expected to maintain a "C" average per semester.
 2. Any anticipated change in your study or vocational objective must be reported to your counselor.
 3. Dropping of any course must be reported.
 4. Any disciplinary action must be reported to your counselor.
 5. You must make arrangements to contact your counselor during the summer months to evaluate your progress.
 6. Upon completion of your program, you have the responsibility to keep in touch with your counselor and notify him/her of your employment.

Individual's Signature	Date	Counselor's Signature	No.	Date
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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 the Pell Grant on an annual basis and provide copies of the results to this office.
- B. Reports to your counselor:

Name: [CounselorName]
Address: [Address]
[City] [State] [PostalCode]

1. Immediately after enrollment and registration, report the following
 - a. Title of each course and number of credit hours for each.
 - b. 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.
 - c. 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.
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.

SIGNATURE _____

_____ Date

SIGNATURE _____

_____ Date

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

LETTER FOR STUDENTS IN TRAINING INSTRUCTIONS

This letter is to be mailed to the individual during the Spring Semester.

- Self-explanatory
- The content of the letter will remain the same.
- It will be necessary for the counselor to create the letter on local office letterhead.

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 ~~will write a letter and mail it to the Arkansas Rehabilitation Services office in one of the enclosed envelopes.~~ Statements to be included are: 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.)

~~MONTHLY TRAINEE LETTER FORM INSTRUCTIONS~~

Self-explanatory.

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

TRAINING PROGRESS REPORT INSTRUCTIONS

~~This progress report is to be submitted by the officer, or instructor in charge as pre-arranged by the counselor. The counselor and vendor determine time frame.~~

ARKANSAS REHABILITATION SERVICES STUDENT HEALTH SURVEY

STUDENT'S SOCIAL SECURITY # _____

STUDENT'S NAME: _____ SEX: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____
City Zip Code

COUNTY: _____ PHONE: _____ HIGH SCHOOL: _____

FAMILY DOCTOR: _____

The purpose of this form is to help us locate any student with a 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.

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

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

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: _____

STUDENT HEALTH SURVEY INSTRUCTIONS

This form is to be used by the counselor to survey high school students.

VR Case and Closure/Amendment Information

Client Name: _____

Date of Birth: _____

Is Client Working? _____

Level of Education at Closure:

Impairments

Primary Impairment:

Cause of Primary Impairment:

Other Impairment:

Cause of Other Impairment:

___ Significantly Disabled?

___ Projects with Industry (IAM CARES, etc.)?

Other Income at Closure

Please Enter Monthly Amount

AMOUNT

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

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:

Monthly 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?

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:

Monthly 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?

If Used:

CRP Vendor:

ACTI:

Type of ACTI services provided:

Complete?

Work Status:

Integrated Work Setting: ___

Supported Employment Status at Closure:

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?

Reason Services on Plan were not provided:

Reason for closure: _____
Date Closed: _____

SIGNATURE

Date

SIGNATURE

Date

ARKANSAS REHABILITATION SERVICES CLIENT FOLLOW-UP 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

CLIENT FOLLOWUP INSTRUCTIONS (M-17)

~~This form is used to assist the counselor to secure follow up information from the individual.~~

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

**REGISTERED LETTER -- CLOSURE OF CASE RECORD OF SERVICES
INSTRUCTIONS**

Letterhead stationery will be used for this letter.

STATE OF ARKANSAS



Department of Career Education Arkansas Rehabilitation Services

Counselor No. _____

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? Yes 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? Yes 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.