

WORK & EDUCATIONAL EXPERIENCE

WORK HISTORY (Most recent first or attach resume)

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason for Leaving Job: _____

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

Employer Name and Address: _____

How did you get this job? _____

Hrs. per Week: _____ Dates Employed: _____ - _____ Gross Wages: _____

Job Title/Skills: _____

Most Liked About Job: _____

Least Liked About Job: _____

Reason Left: _____

EDUCATION & TRAINING

Highest Grade Completed: _____ Special Education [IEP]: Y ___ N ___ Diploma: Y ___ N ___ GED: Y ___ N ___

Did you receive support services in school? Y ___ N ___ Describe (e.g. technology, aide, etc.): _____

High School: _____ College: _____

Degree Obtained: _____ Year: _____

Other Training: _____

Skills/Hobbies (e.g. languages, computer, skills, licenses, volunteer experience, etc.): _____

INFORMATION ABOUT YOUR DISABILITY

DISABILITY/MEDICAL CONDITION (What prevents you from working?)

Describe your limitations to employment: _____

Medical condition (if known): _____

PHYSICIANS/HOSPITAL/CLINIC

Dates of Service

Name(s) and Address: _____

MENTAL HEALTH/PSYCHOLOGIST/SOCIAL WORKER

Dates of Service

Name(s) and Address: _____

MEDICATIONS/TREATMENTS

Name/Type

Dosage/Frequency

MEDICAID Y __ N __

MEDICARE Y __ N __

PRIVATE Y __ N __

MEDICAL COVERAGE

Insurance/Benefit

Claim No.

Provided by Employer

EQUIPMENT NEEDED TO WORK _____

COUNSELOR'S COMMENTS: _____



DEPARTMENT OF HUMAN SERVICES – OFFICE OF REHABILITATION SERVICES

40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ (401) 421-7016 (TTY)

“Helping individuals with disabilities to choose, find and keep employment”

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my record. (Name of Client)

My Date of Birth: ____ / ____ / ____

My Social Security Number: ____ - ____ - ____

II. My information is to be disclosed to/ provided by:

And is to be provided to/disclosed by:

Office of Rehabilitation Services

Name of
Address
City/ST/Zip

Name of
40 Fountain Street
Address
Providence, RI 02903
City/ST/Zip

III. The purpose or need for this release of information is:

- To obtain the information checked below that will assist me in vocational rehabilitation planning
My own personal and private reasons
Other (specify):

IV. The information to be disclosed from my health record: (check all of the boxes that apply)

- Vocational Medical Educational Social
Financial Psychiatric/Psychological Other (specify):
Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)

Specific Information Needed:

Dates of Service: _____ to _____

I would also like the following sensitive information disclosed: (check the applicable box(es))

- Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment
Sexually Transmitted Diseases

V. I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me. (Enter if different from one year after the date below)

Signature of Client Date
Signature of Authorized Representative Relationship to the Client Date

Instructions for Completing Form ORS-37

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.
2. Section I – print name of the client whose information is to be released.
3. Section II – print the name and address of the person or organization authorized to release and/or receive the information. Also, provide the name of the DHS/ORS representative, unit and address that will receive and/or release the information.
4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)
5. Section IV – check all of the boxes that apply.
 - a. Vocational, Medical, Educational, Social, Financial, Psychiatric/Psychological
 - b. Other (*specify*) – specific information identified by the client (e.g., billing, employee health)
 - c. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
 - d. Specific Information Needed – clearly identify the precise information to be disclosed.
 - e. Dates of Service – note the first and last date of service requested.
 - f. **RELEASE OF SENSITIVE INFORMATION** – check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases – patient must check the appropriate box!
6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.
7. Section V – Authorized Representative (e.g., parent, legal guardian, power of attorney)
8. A copy of the completed Form ORS-37 will be given to the client.



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**CURRENT HEALTH AND FUNCTIONAL CAPACITIES
SELF-ASSESSMENT**

Name: _____ Date: _____

Height: _____ Weight: _____ D.O.B.: _____ SS#: _____

Please list the most important problem(s) that interfere with your working: _____

For each area below, choose whether you have EXCELLENT or AVERAGE health or ability in that area or whether you have some problems. This is important information in planning for work.

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
HEARING				
SEEING				
SPEAKING				
SITTING				
STANDING				
WALKING				
KNEELING				
BENDING				
LIFTING				
PUSHING/PULLING				
HANDLING/FINGERING/FEELING				
CLIMBING				
BALANCING				
COORDINATION				
STRENGTH				
ENERGY/STAMINA				
BREATHING				
ALLERGIES				
REMEMBERING				
LEARNING				
READING				
WRITING				
CONCENTRATING				

	EXCELLENT HEALTH/ ABILITY	AVERAGE HEALTH/ ABILITY	SOME PROBLEMS	COMMENTS
MAKING DECISIONS				
SOLVING PROBLEMS				
GETTING ORGANIZED				
COLD/HOT WEATHER				
GROOMING/SELF CARE				
PEOPLE (GETTING ALONG WITH OTHERS)				
NERVOUSNESS/ANXIETY				
DEPRESSION				
MEALS/DIGESTION				
TAKING MEDICATIONS				
USING TRANSPORTATION				
USING ADAPTIVE EQUIPMENT				
JOB SKILLS				
HOW TO FIND AND GET JOBS				
WORK HABITS				
BEING RELIABLE/DEPENDABLE				
WORK RECORD				
OTHER (PLEASE LIST				

How often have you been hospitalized in the last two years? _____

Do you use? () Tobacco () Alcohol () Other Drugs If yes, how much? _____

Do you have a history of dependency on () Drugs () Alcohol

If so, what is the date of your sobriety? _____

In planning for work, how concerned are you about loss of SSI/SSDI benefits? _____

This is the best estimate of my abilities and limitations.

Signature