Missouri
DEPARTMENT OF ELEMENTARY & SECONDARY
EDUCATION™

Office of Adult Learning and Rehabilitation Services

Questionnaire for Vocational Rehabilitation Services

SSN : _____

AWARE Personal Information

Last Name _____ First Name _____ Middle Name _____

Preferred Name _____ Title/ Honorific _____ (i.e Jr., II, MS, PhD., etc.)

Male ☐ Female ☐ Birth Date: _____

Previous Last Name _____

Home Address _____
(Street, Route, P.O. Box #, etc.)

City: _____ State: _____ Zip: _____ — _____ County: _____

Mailing Address if different from above: _____

Primary Phone Number _____ ☐ Voice ☐ TDD ☐ Fax

Second Phone _____ ☐ Voice ☐ TDD ☐ Fax

E-Mail Address: _____

RACE & ETHNICITY:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White

If Hispanic or Latino, check more than one.
i.e. Hispanic & American Indian

What is your primary language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other

Citizenship Status: ☐ Employment Authorized Status ☐ Other _____
☐ U.S. Citizen

Will you require any accommodations? _____

Please list at least 2 people whom we may contact in an attempt to locate you, should your current contact information become outdated. Please include case managers, probation/parole, etc.

1. Last Name: _____ First Name: _____
   Relationship: _____ Address/City/Zip _____
   Home phone: _____ Mobile or work phone: _____
   E-Mail address: _____
2. Last Name: _____ First Name: _____
   Relationship: _____ Address/City/Zip _____
   Home phone: _____ Mobile or work phone: _____
   E-Mail address: _____

* * * * *

Do you live in a private residence? ☐ yes ☐ no

If no, please describe: _____

_____

Marital Status: ☐ divorced ☐ married
☐ never married ☐ separated ☐ widowed

Who referred you to us? _____

Number of family living in your household: _____ Number of dependents: _____ Monthly Amount

What is your total Gross Family Monthly Income amount? $ _____

Who is your Primary Source of financial support ? _____

Please check yes or no and provide monthly amount if **you** receive any of the following Public Support Types.

Do you receive Supplemental Security Income Aged benefits (SSI-A)?	☐ yes	☐ no	$
Do you receive Supplemental Security Income Disability benefits (SSI -D)?	☐ yes	☐ no	$
Do you receive Social Security Disability Insurance benefits (SSDI)?	☐ yes	☐ no	$
Do you receive disability benefits from the Veterans Administration (VA) ?	☐ yes	☐ no	$
Do you receive TANF benefits from the Family Support Division?	☐ yes	☐ no	$
Do you receive General Assistance benefits from the Family Support Division?	☐ yes	☐ no	$
Do you receive Workers Compensation Benefits due to a work injury?	☐ yes	☐ no	$
Do you receive Other Disability cash benefits from any other source?	☐ yes	☐ no	$
Do you have any Other Public cash benefits not listed above?	☐ yes	☐ no	$

Total Household Monthly Income $ _____

Health Insurance, please check if you have:

☐ Medicaid (i.e. MO HealthNet)

☐ Medicare

☐ None

☐ Private Insurance through other means

☐ Private Insurance through own employment

☐ Public Insurance from other sources (i.e. Workers Compensation, VA Healthcare, etc.)

What is your level of Education? _____

Have you received services under an Individualized Education Program (IEP)? ☐ yes ☐ no

Are you currently a high school student ? ☐ yes ☐ no MOSIS # _____

Transistion Program Participant ☐ yes ☐ no

High School

School Name | City & State

Highest Grade Completed | Dates Attended

Other Training

School Name | City & State

Graduated / Completed ☐ yes ☐ no

Area of Study

Degree/Certificate Earned | Dates Attended

List Your Last Two Jobs:

1. _____
(Employer Name & Address) (Job Title) (Weekly Hours and Salary)

_____
(Dates Employed: MM/YY – MM/YY) (Disability-Related Problems Affecting job)

2. _____
(Employer Name & Address) (Job Title) (Weekly Salary)

_____
(Dates Employed: MM/YY – MM/YY) (Reason for leaving)

3. Other Work Experience: _____

_____

_____

* * * * *

AWARE Special Programs

Have you been referred by or receiving services from the following programs? If so check box.

☐ COOP Program (High School) ☐ Center for Independent Living (CIL) Referral

Are you a Veteran? ☐ yes ☐ no

(If yes, list dates of service) _____

Do you have a Military Service Connected Disability? ☐ yes ☐ no

Migratory or Seasonal Farm Worker Program? ☐ yes ☐ no

Projects with Industry? ☐ yes ☐ no