

**VR-118X**

**Entry Services**

**118X-Entry Level II**

|  |  |  |
| --- | --- | --- |
| AV#: | (7 digits) | Click to enter |
| ACCES-VR ID#: | (6 digits) | Click to enter |
| CAMS ID #: | (10 digits) | Click to enter |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| VR District Office: | Click to enter | | Provider: | Click to enter | |
| Participant First Name: | | Click to enter | Participant Last Name: | | Click to enter |
| Participant Phone Number: | | Click to enter | | | |
| Participant Email Address: | | Click to enter | | | |

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| **Checklist** | | | | | |  |  |  |  |  |  |
|  | Application for VR Services (VR-04) | | | | | | | |  |  |  |
|  | Information Release Authorization (VR-21) (3 Copies) | | | | | | | | |  |  |
|  | Information Release Authorization (VR-22) (3 Copies) | | | | | | | | |  |  |
|  | Confidential Health Assessment (VR-26) | | | | | | | |  |  |  |
|  | Application Information Sheet | | | | | | | |  |  |  |
|  | Voter Registration | | | | | | | |  |  |  |
|  | Other Information: | | Click to enter | | | | | | | | |
|  |  | |  | |  |  |  |  |  |  |  |
| Disability Information | | |  | |  |  |  |  |  |  |  |
|  | Documentation of SSI/SSDI/DSS | | | | | |  |  |  |  |  |
|  | Physician Cover Letter with Release to Work and Estimated Physical Capacities Form | | | | | | | | | | |
|  | WC Authorization to Disclose (OC-110A) | | | | | | | |  |  |  |
|  | Medical/Psychological Report | | | | | |  |  |  |  |  |
|  |  | Specify (Type and Date): | | Click to enter | | | | | | | |
|  |  | Specify (Type and Date): | | Click to enter | | | | | | | |
|  |  | Specify (Type and Date): | | Click to enter | | | | | | | |
|  |  | |  | |  |  |  |  |  |  |  |
| **Observations:**  (Please provide detailed information regarding the individual’s physical or mental impairment, functional limitations, impediments to employment, treatment history (as applicable), education and work history.) | | | | | | | | | | | |
| Click to enter | | | | | | | | | | | |
|  | | |  | |  |  |  |  |  |  |  |

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| **Completed By:** | | | | |
|  | |  | Click to enter | |
| Qualified Staff Signature | |  | Date |  |
| Click to enter | |  | Click to enter | |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |

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| --- |
| **For ACCES-VR use Only:** |
| If packet is incomplete, please note the date the provider was notified: |
| Date: |