

# Bureau of Rehabilitation Services INTAKE QUESTIONNAIRE

Case # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
BRS use only

Social Security Number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Name: \_\_\_\_\_  
First Middle Initial Last (Maiden Name)

Telephone #(\_\_\_\_\_) \_\_\_\_\_ e-mail \_\_\_\_\_

Cell Phone# (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
number & street name  
\_\_\_\_\_ city/state zip code

(additional/new addresses):  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ (age \_\_\_\_\_) gender \_\_\_\_\_ (M/F)

Someone who will always know how to reach you:

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

Phone Number \_\_\_\_\_

Who referred you to BRS? \_\_\_\_\_

Have you ever received services from BRS before? Yes\_\_\_ No\_\_\_ If yes, name of counselor; office; dates:  
\_\_\_\_\_  
\_\_\_\_\_

**RACE/ETHNICITY** (please check all that apply):

(This information is collected to help us to meet our Federal requirements to provide services fairly to all individuals)

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

Are you a citizen? Yes\_\_\_ No\_\_\_ If no, country of origin \_\_\_\_\_ (Please submit copy of Visa or "Green Card"/proof of permission to work in this country)

BRS provides many different services to help people with disabilities to be successful with employment. You should receive a BRS Consumer Handbook describing how BRS works, and what services BRS provides. Before we can help you with your employment problems, we must understand your needs.

Please tell us about your disability, and how it causes problems for you with employment -

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What services or assistance do you need from BRS to help you to go to work or keep your job?

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What is the highest grade you completed in school? \_\_\_\_\_

When? \_\_\_\_\_ Where? \_\_\_\_\_

Did you receive services under an IEP (Special Education)? Yes\_\_\_\_ No\_\_\_\_

Do you have any special certificates or training? \_\_\_\_\_

Please describe your living arrangements (if you live with family members please tell us about their relationship to you, ages, employment, etc.)

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Other agencies or persons who are helping you (Please list person's name and phone number)

DDS: \_\_\_\_\_  
(Dept. of Disability Services) Name phone number

DMHAS: \_\_\_\_\_  
(Dept. of Mental Health & Addiction Services) Name phone number

DCF: \_\_\_\_\_  
(Dept. of Children and Families) Name phone number

Other: \_\_\_\_\_  
Name phone number  
\_\_\_\_\_  
Name phone number

What type of transportation do you have available on a regular basis?  
Private \_\_\_\_\_ Public \_\_\_\_\_ Other \_\_\_\_\_

Do you have a valid driver's license? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_  
Have you ever had your license suspended? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, why? \_\_\_\_\_

Are you a Veteran? Yes \_\_\_\_\_ No \_\_\_\_\_

If you have ever been convicted of a felony, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you are you on probation or parole, name/phone number of Probation/Parole Officer:  
\_\_\_\_\_  
\_\_\_\_\_

What are your hobbies & interests? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



BENEFITS ASSESSMENT CHECKLIST

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

Name: \_\_\_\_\_

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

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

Social Security #: \_\_\_\_\_

Phone: \_\_\_\_\_

Monthly Amount of Any Government Benefits You are Receiving:

- \$ \_\_\_\_\_ Social Security Disability Insurance (SSDI)
\$ \_\_\_\_\_ Supplemental Security Income (SSI)
\$ \_\_\_\_\_ Worker's Compensation
\$ \_\_\_\_\_ Unemployment Benefits

- State Financial Assistance:
\$ \_\_\_\_\_ SAGA (State Admin. Gen'l Assistance)
\$ \_\_\_\_\_ TFA (Temporary Family Assistance)
\$ \_\_\_\_\_ State Supplement
\$ \_\_\_\_\_ Food Stamps

Other(describe): \_\_\_\_\_

Medical Coverage:

Yes No Unknown

Do you have -

- Medicaid coverage?
Medicare coverage? Part A.....PartB.....Part D.....
ConnPACE?
Private medical insurance through employer?.....
Private medical insurance through other sources? ....
VA medical coverage? (Full\_\_\_ Partial\_\_\_).....

Monthly Amount of Other Income and Benefits:

- \$ \_\_\_\_\_ Gross Wages
\$ \_\_\_\_\_ Private Disability Insurance (Have policy - not collecting? \_\_\_yes \_\_\_no)

Do You Have -

Yes No

- Housing subsidy -(ex. Public Housing, Section 8 voucher, DMR or DMHAS housing)
Waiver services -(ex: PCA waiver; ABI waiver; DMR waiver).....
Are you married?
(If yes, does your spouse receive state or federal assistance?) .....
Do you have dependent children?
(If yes, do your children receive benefits from Social Security Administration (SSA)?
Do your children receive HUSKY medical coverage?
Do you have significant out of pocket disability and/or medical expenses?
Are you using a PASS (Plan for Achieving Self-Support)
Do you have interest, dividend or annuity income?

BRS Counselor: \_\_\_\_\_

Phone: \_\_\_\_\_

Referred by : \_\_\_\_\_

Phone: \_\_\_\_\_

I give permission for the Connect to Work Project to obtain further information regarding my benefits in preparation for our discussion.

Signature

Date

## EMPLOYMENT EXPERIENCE

### CURRENT OCCUPATION AND JOB DUTIES:

Dates: From \_\_\_\_\_ to \_\_\_\_\_ (PRESENT) \_\_\_\_\_

Company Name: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Job Title/Job Duties: \_\_\_\_\_

Hours per week \_\_\_\_\_

Wages: \$ \_\_\_\_\_ per (circle):    Hour    Week    Month

### PREVIOUS JOBS (list most recent job first)

Dates: From \_\_\_\_\_ to \_\_\_\_\_

Company Name: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Job Title/Job Duties: \_\_\_\_\_

Reason Left Job \_\_\_\_\_

Did your disability cause any difficulties on the job? (If yes, describe) \_\_\_\_\_

Dates: From \_\_\_\_\_ to \_\_\_\_\_

Company Name: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Job Title/Job Duties: \_\_\_\_\_

Reason Left Job \_\_\_\_\_

Did your disability cause any difficulties on the job? (If yes, describe) \_\_\_\_\_

**ADDITIONAL PREVIOUS JOBS** (list most recent jobs first)

Dates: From \_\_\_\_\_ to \_\_\_\_\_

Company Name: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Job Title/Job Duties: \_\_\_\_\_

Reason Left Job \_\_\_\_\_

Did your disability cause any difficulties on the job? (If yes, describe) \_\_\_\_\_

Dates: From \_\_\_\_\_ to \_\_\_\_\_

Company Name: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Job Title/Job Duties: \_\_\_\_\_

Reason Left Job \_\_\_\_\_

Did your disability cause any difficulties on the job? (If yes, describe) \_\_\_\_\_

Dates: From \_\_\_\_\_ to \_\_\_\_\_

Company Name: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Job Title/Job Duties: \_\_\_\_\_

Reason Left Job \_\_\_\_\_

Did your disability cause any difficulties on the job? (If yes, describe) \_\_\_\_\_

(please use additional pages as needed)