

KINGSTON CITY SCHOOL DISTRICT

Kingston High School
403 Broadway
Kingston, NY 12401-4617
Phone (845) 331-1970

Dr. Paul J. Padalino
Superintendent

Tina Montano
Acting Principal

Dear Parent/Guardian:

You are receiving this notice because your student may have an Individual Education Plan (IEP) or a 504 Service Plan (or was recently declassified). Students in KHS with an Individualized Education Plan or a 504 Service Plan may be eligible for Adult Career and Continuing Education Services-Vocational Rehabilitation Program (ACCES-VR).

ACCES-VR is a Higher Education State program to assist students in the transitional high school years and throughout adult life. Services while in high school may include additional college and/or career counseling, paid training, internship opportunities, financial assistance for continuing education (post-secondary), and other programming.

Here is an attached application that can be printed or mailed home to you. At the bottom of this letter, we have included the website resource for you to obtain more information about ACCES-VR.

Filling out the application and mailing it back to Ms. Dierna means that the application process will begin, and we will see if the student qualifies for services. Once the state is in possession of the application, the student will receive a meeting request on TEAMs during the school day. This meeting will be Chaired by Ms. Tina Dierna, KHS Transition Coordinator, the student, the ACCES-VR Vocational Coordinator. A parent/guardian will be invited to join us virtually or over the phone.

ACCES VR Website: <http://www.acces.nysed.gov/vr>

Thank you,

Tina Dierna, LMSW
Transition Coordinator
KHS Certified School Social Worker
Room: Main 111
Phone: 845-943-3813



Please return the completed form to:

District Coordinator
KCS D

Tina Dierna, KHS

403 Broadway
Kingston, NY 12401

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing
Education Services-Vocational Rehabilitation
(ACCES-VR)

Application for VR Services

VR-04 (7/14)

Please print or type all entries

NAME Last First Middle Initial			GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
If you have been known by another name , enter here: Last First Middle Initial			
HOME ADDRESS Street			Apartment Number
City	State	Zip + 4 Code	County
			SOCIAL SECURITY NUMBER □□□-□□-□□□□
If your MAILING ADDRESS is different than your home address, please complete the mailing address information below.			
MAILING ADDRESS Street			Apartment Number
City	State	Zip + 4 Code	County
PHONE NUMBER(S) where we can reach you or leave a message: Area code 1. () - Home <input type="checkbox"/> Cell <input type="checkbox"/> Other <input type="checkbox"/>		Area code 2. () - Home <input type="checkbox"/> Cell <input type="checkbox"/> Other <input type="checkbox"/>	Best time to call 1. 2.
Email: _____		DATE OF BIRTH Month Day Year □□-□□-□□	
Race/Ethnicity-Choose <u>ALL</u> that apply. If left blank ACCES will complete. If Hispanic or Latino is checked, please check additional box.		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (includes Indian Subcontinent) <input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White
What is your disability?		Who referred you to us? KHS	MARITAL STATUS: (Circle Response) (1) Married; (2) Widowed; (3) Divorced (4) Separated (5) Never Married
I hereby apply for rehabilitation services: Date _____		Signature of applicant, parent, or legal guardian.	
X (Sign here.)			

• • • Please answer the questions below and on the back of this form. • • •

You do not have to answer these questions now, but your answers will help ACCES-VR process your application.

Have you ever received services from ACCES-VR or its former name, the Office of Vocational and Educational Services for Individuals with Disabilities (VESID)?..... ☐ Yes ☐ No

Are you now receiving services from one or more agencies?..... ☐ Yes ☐ No

If you answered yes, indicate agency name(s), address(es) and contact person(s):

(1)

(2)

Describe how your disability limits your ability to work.

What services are you seeking from ACCES-VR?

Are you disabled because of a work-related injury? ☐ Yes ☐ No

Do you use any assistive devices or aids? ☐ Yes ☐ No

Do you have a NYS driver's license? ☐ Yes ☐ No

Do you have a driver's license from a state other than New York? ☐ Yes ☐ No

Do you have access to a motor vehicle? ☐ Yes ☐ No

Do you use public transportation? ☐ Yes ☐ No

Are you able to leave your home? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Are you a citizen of the United States? ☐ Yes ☐ No

If no, are you legally permitted to work in this country? ☐ Yes ☐ No

Check the benefits you now receive?

☐ SSI ☐ SSDI ☐ Workers Compensation

☐ Other, specify _____

Do you regularly see a doctor or clinic about your disability? ☐ Yes ☐ No, If yes, indicate date of last visit: _____

Please provide the name and address of doctor(s) and clinic(s):

(1) (2)

Circle the highest grade you have successfully completed, and check the applicable box(es)

1 2 3 4 5 6 8 9 10 11 12 GED or High School 13 14 15 16 17 20
Equivalency Diploma ☐ Yes ☐ No College Graduate School Doctorate

Special Education ☐ Yes ☐ No Do you now attend high school? ☐ Yes ☐ No Indicate college degree(s) earned: _____

Name and address of school you last attended: *Name of School* *Address*

List below other people in your household

Full Name	Age	Their Relationship to You

List below the people ACCES-VR can contact if we are unable to reach you using the information on page 1.

Name	Address	Phone

List below your work history (include attachments for additional jobs, if necessary)

Employer Name and Address	Dates Employed From - To	Weekly Earnings	Job Title and Duties, and Reason for Leaving

Persons applying for or receiving rehabilitation services have the right to have any actions or decisions of this Office reviewed. A description of the review process and form can be obtained from any ACCES-VR District Office.

All information will be kept confidential and is subject to verification.

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, pregnancy, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its recruitment, educational programs, services, and activities. Portions of any publication designed for distribution can be made available in a variety of formats, including Braille, large print or audiotape, upon request. Inquiries regarding this policy of nondiscrimination should be directed to the Office of Human Resources Management, Room 528 EB, Education Building, Albany, NY 12234. Requests for publications should be made to the Department's Publications Sales Desk, Room 309, Education Building, Albany, NY 12234.

Information Release Authorization

Name: _____

Print full name

The Office of Adult Career and Continuing Education Services (ACCES-VR) has my permission to release or obtain information from agencies [including the Client Assistance program (CAP)], individuals, or employers as are concerned with my vocational rehabilitation. This information may include reports about my physical or mental condition, official school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services.

I understand that:

- All such information will be treated as confidential and privileged;
- The information will be used only for the purpose of obtaining services offered through ACCES-VR;
- I can withdraw my permission to release or obtain information by writing to ACCES-VR (this will not affect actions already taken with my permission); and
- ACCES-VR may need to use the information to administer the vocational rehabilitation program



Signature

Date

Parent/Guardian Signature (If Under 18 Years of Age)

Date

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its educational programs, services, and activities. Inquiries concerning this policy of nondiscrimination should be referred to the Department's Office for Diversity, Ethics, and Access, Room 530, Education Building, Albany, NY 12234-0001.

ACCES-VR High School Applicant Supplemental Data

All Information Below is Optional but Helpful for Application

Education Information to be completed by person making referral

Referral will be facilitated by including **one or more** of the following: ☐ Current IEP and most recent psychological report
☐ Current 504 Plan and supporting documents ☐ Current Physician Report with diagnosis ☐ Other Relevant Information

Student Name: _____ DOB _____

CSE Classification, 504 or Medical Diagnosis: _____

Grade Most Recently Completed: _____ Expected Year of School Completion: _____

Type of Degree/Certificate Anticipated: ☐ Regents ☐ Local ☐ CDOS ☐ Skills & Achievement

School District Student Resides In: _____

School Student Attends: _____ AM _____ PM _____

Name of person making referral: Tina Dierna Title: Transition Coordinator
Email Contact: tdierna@kingstonschools.org Phone Number: 845-943-3813

Can Choose to Complete Following with ACCES-VR Counselor at First Meeting

Health, Residence & Work Questionnaire: To Be Completed By Student And Parent/Guardian

Do you have or have you ever had any of the following conditions?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Disease/Rash |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Speech/Language Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Ulcers/Colitis/Crohn's Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Orthopedic Limitations | <input type="checkbox"/> Vision (not corrected by glasses) |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> HIV Related Diseases | <input type="checkbox"/> Respiratory Disorder | <input type="checkbox"/> Other: _____ |

List of Medications: _____

Medical Insurance at Application:

☐ Medicaid ☐ Medicare ☐ Other Private ☐ Private Through Employment ☐ Workers Compensation ☐ None

Living Arrangements at Application:

☐ Private Residence ☐ Foster Care ☐ Homeless ☐ Community Residence ☐ Halfway House
☐ Substance Abuse Treatment Facility ☐ Mental Health Facility ☐ Correctional Facility ☐ Other

Work Status at Application:

☐ Employed with a job coach ☐ Employed on my own ☐ Not presently employed