TEXAS WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services

Request to Receive Pre-Employment Transition Services

Required Elements Needed for Federal Reporting	
The confidentiality of all information requested on this form is protected by 34 CFR 361.38.	
Student First Name:	Student Last Name:
Date of Birth:	SSN / Driver's License or State ID # / or School ID #:
Race & Ethnicity (select all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino ☐ Black or African American ☐ White	
Start Date for Pre-ETS activity:	
Disability:	
Disability verified by documentation/observation? ☐ Yes ☐ No	

Additional Student Information			
Email Address:		Phone: ( )	
Address:			
City:		State:	ZIP:
Currently Enrolled in School: ☐ Yes ☐ No	Name of School:		
Section 504 Plan: ☐ Yes ☐ No	Individualized Education Program: ☐ Yes ☐ No		

Parent/Representative Information			
Parent/Representative First Name:	Parent/Representative Last Name:		
Email Address:		Phone: ( )	
Address:			
City:		State:	ZIP:

Method of Contact (select one): Face to Face ☐ Phone ☐ Virtual ☐	
Customer has Internet: Yes ☐ No ☐	Customer has Computer/Laptop: Yes ☐ No ☐
Customer is able to Video Conference: Yes ☐ No ☐	

By signing below:

- I am requesting Pre-Employment Transition Services from the Texas Workforce Solutions – Vocational Rehabilitation Services (TWC-VR).
- I am a student with a disability, and I have provided appropriate documentation of my disability to TWC-VR.
- I understand that in order to pursue additional services through TWC-VR I will need to complete an application and provide TWC-VR with more information needed to determine my eligibility for those additional services.
- I have received a copy of the “Can We Talk?” brochure outlining the VR appeals procedures.

Signatures	
Note: A parent or representative must sign if the student is a minor (under 18 years of age).	
Student Printed Name:	
Student Signature: **X**	Date:
Parent/Representative Printed Name:	
Parent/Representative Signature: **X**	Date:

TEXAS WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services

Permission to Collect Information

Identifying data:	Return information to:
Customer's name: _____	Enter name, address, city, state, and ZIP code:
Date of birth: _____	Texas Workforce Solutions-VRS
Case ID number: _____	ATTN: Jennifer Greene
Customer's phone number: (___) _____	206 Highway 332 W
	Lake Jackson, TX 77566 Fax: (979)258-7109

Requested information about treatment or attendance covers this time period:

From _____ through case closure

Organization or Individual Authorized to Disclose

Instructions: Separate release forms must be completed for each organization or individual.

As the applicant or customer, I authorize the provider listed below to disclose the protected health information and other personal information listed under "Information Subject to Disclosure" to Vocational Rehabilitation Services (VR).

Enter the name of the organization **or** individual:

Fort Bend Independent School District

Acknowledgment of Notice

As the applicant or customer, I acknowledge that VR has provided me a copy of this authorization and has notified me that:

- I may refuse to sign this authorization to allow VR access to my protected health information and other personal information in the possession of others, and that, if I refuse to sign this authorization, I must still provide information about myself to my counselor;
- a failure to provide information may cause delay, or the termination, of VR services to me;
- VR requires protected health information and other personal information about me and perhaps about my family in order to develop my rehabilitation program;
- VR may receive the protected health information from me or from others (such as health care providers whom I authorize to release this information to VR);
- state and federal law permits VR to collect information about me;
- my records (including alcohol and/or drug abuse information, mental status information, and human immunodeficiency virus test results) are protected by federal regulation and/or state law from disclosure; and
- VR may redisclose or be required to redisclose some or all of this information in response to a subpoena, or to any one or more of the following: (i) medical or psychotherapeutic consultants from whom VR purchases services to evaluate my case; (ii) community rehabilitation programs involved with my case; (iii) educational institutions in connection with my rehabilitation program; or (iv) my attorney. If redisclosed, this information may no longer be protected from further disclosure by law, particularly by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Information Subject to Disclosure

The authorized organization or individual is permitted to release to VR the information checked below (including information regulated by the HIPAA Privacy Rule and its regulations; 42 U.S.C. 290dd-2; Texas Rules of Evidence, and Texas Health and Safety Code §571.015[c]).

VR staff, check all that apply:

- ☐ Psychological evaluations and psychotherapeutic notes
- ☐ Alcohol and/or drug abuse treatment records
- ☐ Texas Department of Public Safety records
- ☐ Texas Department of Criminal Justice records
- ☐ Medical treatment records
- ☐ Protected health information
- ☐ Mental health records
- ☒ School records and grades
- ☐ Inpatient and outpatient hospitalization records
- ☒ Other (be specific): Please include all information such as the student's IEP, 504 plan, accommodations, FIE, and diagnosis

Purpose for disclosure: The information released by this authorization is used in connection with the applicant or customer's rehabilitation program.

Period of validity of authorization: As the applicant or customer, I understand that I may revoke this release in writing at any time after signing it except that any revocation does not affect an action taken based on this release. Until revoked by me, this release remains valid for either a period of 365 days from the date signed, or until the date when I cease to be a VR applicant or customer, whichever date occurs earlier.

Miscellaneous: As the applicant or customer, I further authorize VR and those disclosing my protected health care information and personal information under this authorization to exchange such information electronically (for example, email or fax). A photocopy of this authorization is fully acceptable as an original.

Applicant or Representative Signature

Signature of applicant or customer: **X**	Printed name of applicant or customer:	Date:
Signature of parent, guardian, and/or representative (if necessary): **X**	Printed name of parent, guardian, and/or representative (if applicable):	Date:
Description of representative's authority to act on behalf of the customer:		
Signature of witness (if necessary): **X**	Printed name of witness (if applicable):	Date:
Signature of VR representative: **X**	Printed name of VR representative: Jennifer Greene	Date: