



Commonwealth of the Northern Mariana Islands
Office of Vocational Rehabilitation



OVR INTAKE / REFERRAL FORM

Date: _____

Referral Source: Self Agency _____
 Other _____

Previous VR consumer? Yes No Previous Counselor's Name: _____

If yes, date closed: _____ Outcome: _____

NAME: _____
(Last) (First) (Middle)

Address: _____
(P.O. Box, Street) (Island, Zip Code) (Village)

Phone#:(H) _____ (W) _____ E-mail Address: _____

Date of Birth: _____ Age: _____ Gender: _____

Social Security #: _____ Ethnicity: _____

Primary Language: _____

Citizenship: USA FAS Non-USA (please specify) _____

If non-US: Alien Registration/Immigration Card # _____

Permit Expiration Date: _____

PROGRAM ASSIGNED (to be used by OVR staff only)

Employment

- BS - Basic-Support Services
- SE - Supported Employment Independent Living
- ILS - Independent Living Services
- ILOB - Independent Living Older Blind (55 years and over only)