VIRGINIA CAREER WORKS
PIEDMONT REGION

Workforce Innovation and Opportunity Act (WIOA)
Disability Status Verification

A proud partner of the americanjobcenter network

WIOA Applicant Name: ____________________

I authorize the Virginia Department of Aging and Rehabilitative Services (DARS) to release the information noted below for the purpose of determining eligibility for the Workforce Innovation and Opportunity Act program.

WIOA Applicant Signature *Date:*

Parent/Guardian Signature (if needed) *Date:*

●●

TO BE FILLED OUT BY DARS REPRESENTATIVE ONLY

DARS Office Name: ____________________
Address: ____________________
City/State/Zip: ____________________
Contact Person: ____________________
Phone: ____________________

Is the above named applicant receiving services from your office for a disability? ☐ Yes ☐ No

If yes, the disabling condition is: (*Check all that apply*)

☐ Physical Impairment ☐ Learning Disability ☐ Substance Use Disorder
☐ Cognitive Disorder ☐ Mental Health Disorder

Comments/Other:

____
____
____

DARS Representative Signature *Printed Name*

Title *Date*

PLEASE RETURN THIS FORM TO:

Name: ____________________
Phone: ____________________
Fax: ____________________
Email: ____________________