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
☐ Mental Retardation ☐ Emotional Disturbance

Comments/Other:

_____
_____
_____

DARS Representative Signature *Printed Name*

Title *Date*

PLEASE RETURN THIS FORM TO:

Name: _____
Phone: _____
Fax: _____
Email: _____