DOR Forms

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Enrollment For Vocational Rehabilitation Services

DR 210 (REV 09/20)

Please complete this form to request vocational rehabilitation services. If you need assistance, a Department of Rehabilitation staff member would be happy to assist you.

***Required Field**

***Last Name:**

***First Name:** | **Middle Name:**

Other Name(s) Used:

Social Security Number: XXX-XX-XXXX | ***Date of Birth:**

Phone Number:

Email:

Gender: ☐ Male ☐ Female ☐ Decline to State

***Street Address:**

Mailing Address (if different):

What is your race and ethnicity? (check all that may apply)

☐ American Indian/Alaskan Native ☐ Asian Indian ☐ Black or African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hawaiian
☐ Hispanic or Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to State

***Where do you reside?**

☐ Private Residence ☐ Adult Correctional Facility
☐ Nursing Home ☐ Community Residential Facility or Group Home
☐ Halfway House ☐ Homeless/Shelter
☐ Rehabilitation Facility ☐ Substance Abuse Treatment Center ☐ Other

***What is your primary source of money or income?**

☐ Family and Friends ☐ Personal Income
☐ Public Support (SSI, SSDI, TANF, etc.) ☐ All Other Sources

***Who referred you to the Department of Rehabilitation? Some examples are Community Rehabilitation Programs, Community Partners/Schools, Family/Friends, Employers, Other State Agencies, and Self-referral.**

***What amount of money do you get each month from the following sources?**

SSI Aged _____ SSI Blind _____ SSI Disabled (SSI) _____

Veterans' Disability Benefits at Application _____ SSDI Disabled _____

Temporary Assistance for Needy Families (TANF) _____

General Assistance (State or Local) _____ Workers' Compensation _____

Unemployment Insurance _____ Other Disability_____ Other _____

***What type of medical insurance do you have?**

☐ Affordable Care Act Exchange (Obamacare) ☐ Medicare Medicaid/Medi-Cal

☐ Private Insurance Through Other Means ☐ Medicare

☐ Private Insurance Through Own Employer Soon ☐ None

☐ Private Insurance Through Own Employer ☐ Public Insurance from Other Sources

***Are you a Veteran?** ☐ Yes ☐ No

***Did you graduate from High School? (Select from options below)**

☐ Yes, Year? _____ ☐ No ☐ GED or Equivalent, Year? _____ ☐ In High School

If you are in high school, please answer the following questions:

***Do you have an Individualized Education Program (IEP)?** ☐ Yes ☐ No ☐ Not Sure

***Do you have a Section 504 Plan?** ☐ Yes ☐ No ☐ Not Sure

***Describe your disability or disabilities.**

***Describe how your disability(ies) impact you in your daily activities, school, or current or future job.**

***Describe what type of assistance you might require, or how you would like the Department of Rehabilitation to help? Some examples are Job Exploration and Career Counseling, Training, Education, Job Search and Placement Assistance, and Assistive Technology.**

Are you or will you be legally authorized to work in the United States? ☐ Yes ☐ No

By signing below, I am requesting vocational rehabilitation services to seek competitive integrated employment and confirm that the information provided above is accurate to the best of my knowledge.

***Applicant's Signature** ✍	**Date Signed**
***Parent/Guardian's Signature (required for minor)** ✍	**Date Signed**
***Counselor's Signature** ✍	**Date Signed**

The California Information Practices Act of 1977 (Civ. Code § 1798.17) and the Federal Privacy Act (5 U.S.C. § 552a) require this notice be provided to individuals when collecting personal information. The information requested on this form is necessary for the limited purposes of determining eligibility for vocational rehabilitation services, identification of individuals, or meeting the Department of Rehabilitation's reporting requirements. (29.U.S.C § 705(2); 34 C.F.R. § 361.38; and Welf. & Inst. Code §§ 19005 and 19011). Please do not provide any personal information on this form that is not requested.

YOUR RIGHTS AND REMEDIES

If questions or issues arise while you are an applicant or a consumer of the Department of Rehabilitation (DOR), talk with your Rehabilitation Counselor. You may also request an informal meeting with your Rehabilitation Counselor's Team Manager.

You have the right to request an administrative review with the District Administrator. You may also seek, as set forth below, an administrative review concurrently with a formal request for mediation and/or fair hearing. However, most problems can be resolved informally and more quickly at the district level. You may bring a family member, other representative, or advocate with you any time you meet with the DOR staff.

CLIENT ASSISTANCE PROGRAM. To seek an advocate or for information regarding vocational rehabilitation services or the appeal process, the Client Assistance Program (CAP) administered by Disability Rights California may be available to assist you. Information is available at the Disability Rights California website (http:www.disabilityrightsca.org), by phone at 800-776-5746 or 800-719-5798 TTY/TDD (Telecommunication Device for the Deaf and Hard of Hearing), or at the DOR website (http:www.dor.ca.gov).

You have the right to take any of the following steps should issues arise:

REHABILITATION COUNSELOR. Most misunderstandings and issues can be resolved by talking them over with your Rehabilitation Counselor. It is your responsibility to let your Rehabilitation Counselor know there is an issue.

TEAM MANAGER. If you believe that you and your Rehabilitation Counselor cannot resolve the issue, you may request an informal meeting with the Team Manager to discuss the issue.

ADMINISTRATIVE REVIEW. You may request an administrative review by the District Administrator within one year of the action or decision. An administrative review decision will be rendered within 15 calendar days of the date of your request, unless you agree to a later date. If you disagree with an administrative review decision, you may file a request for fair hearing within 30 calendar days of the receipt of the written decision of your administrative review.

MEDIATION. Mediation is another option for resolving disputes with the DOR. You may file a request for confidential mediation within one year of the DOR action or decision with which you disagree. A qualified, impartial mediator can help you find solutions that are satisfactory to you and the DOR. If the DOR agrees to mediate, the mediation will be held within 25 calendar days from receipt of the request, unless you agree to a later date. A written request for mediation and/or fair hearing may be filed concurrently.

FAIR HEARING. If you are dissatisfied with any action or decision of the DOR relating to your application or receipt of vocational rehabilitation services, you may file a request for a fair hearing within one year of the DOR action or decision or within 30 calendars days of the receipt of written decision of your administrative review (see above). A fair hearing will be held within 60 calendar days of the receipt of your written request, unless you agree to a later date. At the hearing, you may appear in person, and may be accompanied by a representative or advocate of your choice. It may be to your benefit to first work through the administrative

review process or mediation (see above) before requesting a fair hearing. If you are not satisfied with the fair hearing decision, you may file a Writ of Mandate with the California Superior Court within six months of the decision.

To request a mediation and/or fair hearing, please obtain form DR 107 Request for Mediation and/or Fair Hearing from one of the following options: contact the DOR Mediation and Fair Hearing Office by phone at 916-558-5860 or by email at DOR Appeals Info (appealsinfo@dor.ca.gov); visit the DOR website (http:www.dor.ca.gov); or contact a CAP advocate (see CAP contact information above).

DISCRIMINATION. If you believe that the DOR or its contractor or grantee has unlawfully discriminated against you because of one or more of the following protected categories, your race, color, religion, ancestry, physical or mental disability, national origin, medical condition, genetic information, sexual orientation, marital status, age, gender, gender identity, gender expression, military status, or veteran status or retaliation, you have the right to pursue the following options: 1) Make an oral or written request for an administrative review to the District Administrator, who oversees the office where your case is assigned. The request should include: your name, address, and phone number; the name and title of the person against whom the complaint is being made; a description of the alleged discrimination; the protected category; and the remedy being sought. 2) File a discrimination complaint directly with DOR's Office of Civil Rights (OCR). For more information or to obtain a discrimination complaint form contact the DOR's OCR directly by phone at 916-558-5850.
3) File a complaint with the U.S. Department of Education's Office for Civil Rights. For more information contact the U.S. Department of Education's Office for Civil Rights directly by telephone at 800-421-3481.

Requests for administrative review and complaints of discrimination must be made within 180 days of the date of alleged discrimination.

STATE OF CALIFORNIA DEPARTMENT OF REHABILITATION

SUPPLEMENTAL PERSONAL INFORMATION

DR 222A (Rev. 2/12)

Name:	Gender: ☐ Male ☐ Female
Email Address:	TTY

1. Race and Ethnicity Checklist (optional)
   - ☐ American Indian or Alaskan Native
   - Asian Group: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian
   - ☐ Black or African American
   - Native Hawaiian or Other Pacific Islander Group: ☐ Guamanian or Chamorro ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
   - ☐ White
   - ☐ Hispanic or Latino
   - ☐ Other_____
2. What is your primary language?
3. What is your current living arrangement?
   - ☐ Private Residence
   - ☐ Adult Correctional Facility
   - ☐ Community Residential/Group Home
   - ☐ Halfway House
   - ☐ Homeless Shelter
   - ☐ Mental Health Facility
   - ☐ Nursing Home
   - ☐ Rehabilitation Facility
   - ☐ Substance Abuse Treatment Center
   - ☐ Other: _____
4. Are you registered to vote? ☐ Yes ☐ No
5. How many people are in your family?
6. What is your marital status?
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Separated
   - ☐ Never Married
7. What is your family monthly income (gross income)? $ per month
8. What is your primary source of support?
   - ☐ Friends/Family
   - ☐ Own Income
   - ☐ Public Support (please complete the following):
     - $ _____ Supplemental Security Income (SSI) ☐ Aged ☐ Blind ☐ Disabled ☐ Applied ☐ Denied ☐ Pending ☐ Discontinued/Terminated
     - $ _____ Social Security Disability Insurance (SSDI) ☐ Based On Disability ☐ Other ☐ Applied ☐ Denied ☐ Pending ☐ Discontinued/Terminated
     - $ _____ Veteran's Administration (VA)
     - $ _____ Temporary Aid to Needy Families (TANF)
     - $ _____ General Assistance (GA)

$ _____ Worker's Compensation (WC)

$ _____ Other Public Assistance

9. What type of medical insurance do you have?

☐ Medicare ☐ Private (employment) ☐ Worker's Compensation

☐ Medicaid (Medi-Cal) ☐ Private (other) ☐ None

10. What is the highest level of education you have achieved?

☐ No formal schooling ☐ Post-secondary, no degree

☐ Elementary (1-8 grade) ☐ AA/AS degree

☐ Secondary (no HS diploma) ☐ Vocational Tech certificate

☐ Special Education ☐ Bachelor's degree

☐ HS graduate/ equivalency certificate ☐ Master's degree or higher

11. Check if you are or have been involved in the following educational programs:

☐ Individualized Education Program ☐ Transition Program Participant

12. What was the last year you were employed?

13. What is your current work status?

☐ Employed (with support) ☐ Not Employed: Student/secondary education

☐ Employed (without support) ☐ Not Employed: Trainee/Intern/Volunteer

☐ Extended Employment ☐ Self Employed (not BEP)

☐ Homemaker ☐ State Agency Business Enterprises (BEP)

☐ Not Employed: All other students ☐ Unpaid Family Worker

☐ Not Employed: Other

14. If you are working, how many hours do you work per week?

15. How much do you earn? $ per (hour, week, month)

16. Please check any program(s) in which you have participated/are participating:

☐ Veteran ☐ Migrant or Seasonal Farm Worker ☐ Projects with Industry

17. What do you need from the Department of Rehabilitation to gain or maintain employment?

18. What are your employment needs?

19. Other comments:

STATE OF CALIFORNIA DEPARTMENT OF REHABILITATION

HEALTH QUESTIONNAIRE

DR218 (Rev. 05/20)

Date

Applicant's Name			Insurance Coverage Medi-Cal# Medicare# Other
Sex ☐ Male ☐ Female	Height	Weight	

I. APPLICATION REVIEW – Disability(ies) and functional limitation(s) reported on application:

II. REVIEW OF CURRENT HEALTH STATUS –
Please explain any **YES** answer in **COMMENTS** section below.

BODY SYSTEMS – Are you now receiving or have you ever received treatment for:

	NO	YES	WHEN
1. Ear(s)/Hearing Problem	☐	☐	
2. Eye(s)/Visual Problem	☐	☐	
3. Mental/Emotional Problem	☐	☐	
4. Nervous Problem	☐	☐	
5. Lung/Respiratory Problem	☐	☐	
6. Heart/Circulation Problem	☐	☐	
7. Digestive Problem	☐	☐	
8. Kidney/Bladder Problem	☐	☐	
9. Legs/Feet/Arms/Hands Problem	☐	☐	
10. Back Problem	☐	☐	
11. Thyroid	☐	☐	
12. Diabetes	☐	☐	
13. Skin Problem	☐	☐	
14. High Blood Pressure	☐	☐	
15. Joint Problem	☐	☐	
16. Arthritis/Rheumatism	☐	☐	
17. Suppressed Immune System	☐	☐	
18. Other (Specify)	☐	☐	

FUNCTIONAL LIMITATIONS – Is your activity or ability to work currently limited by:

	NO	YES
19. Your Hearing	☐	☐
20. Your Vision	☐	☐
21. Your Ability to Learn/Read	☐	☐
22. Your Ability to Speak	☐	☐
23. Problem Breathing/Coughing	☐	☐
24. Dizziness/Fainting	☐	☐
25. Emotional Problems	☐	☐
26 Weakness (State Where)	☐	☐
27. Numbness (State Where)	☐	☐
28. Pain (State Where)	☐	☐
29. Your Memory	☐	☐
30. Your Ability to Concentrate	☐	☐
31. Spells of Unconsciousness	☐	☐
32. Seizures	☐	☐
33. Problem Balancing	☐	☐
34. Problem Walking	☐	☐
35. Problem Using Hands/Arms/Legs (Specify)	☐	☐
36. Problem Lifting	☐	☐
37. Problem Bending	☐	☐

COMMENTS:

Explain any YES answers in the space below.

Please indicate the specific item number to which you are referring, the specific problem(s)/area(s) affected, and, if undergoing treatment, the name and address of the provider, if other than listed in Sections E, F, or G.

Attach additional sheets if necessary.

38. Problem Standing	☐	☐
39. Problem Climbing	☐	☐
40. Problem Crawling	☐	☐
41. Problem Kneeling	☐	☐
42. Problem Sitting	☐	☐
43. Difficulty with Driving	☐	☐
44. Other (Specify)	☐	☐

III. ADDITIONAL MEDICAL DATA – If not applicable, indicate N/A

A. Indicate if you now or in the past have smoked, abused alcohol, or used drugs (illegal or abused legal). State specifics, including what, amounts, and when:

B. Do you have allergies? ☐ No ☐ Yes If yes, list:

Does this create an interference with your ability to work? ☐ No ☐ Yes If yes, how:

C. MEDICATIONS – List medicines you are now taking:

Do any of these medications interfere with your ability to work? ☐ No ☐ Yes If yes, explain:

D. Have you had any operations or broken bones? ☐ No ☐ Yes If yes, provide specifics and dates:

HEALTH QUESTIONNAIRE

E. DOCTORS/HOSPITALS - From whom/where you have received major medical treatment in the past 2 years

Name	Address (including zip code)	Phone	Date Last Seen	Nature of Treatment

F. CURRENT EXAMINATION – Have you had a physical/general medical examination in the past 12 months?

☐ No ☐ Yes If yes, by whom (include address, zip code, and phone number):

G. FAMILY PHYSICIAN

Name	Address (including zip code)	Phone	Date Last Seen	Nature of Treatment

IV. SUMMARY – List medical & emotional problem(s) you now have which interfere(s) with your ability to obtain/maintain employment:

PROBLEM	HOW DOES THE PROBLEM INTERFERE?

V. This information is true and correct to the best of my knowledge. I have reviewed this information with the counselor and approve the inclusion of this information **(including any self-disclosure regarding the results of HIV serology testing or suppressed immune system)** in my case file with the Department of Rehabilitation.	**VI.** I have reviewed this information with the applicant. All "YES" answers are explained/clarified on this form or attachments.
Applicant's Signature ✍	Counselor's Signature ✍

STATE OF CALIFORNIA DEPARTMENT OF REHABILITATION

EMPLOYMENT RECORD

DR 222B (Rev. 11-20)

INSTRUCTIONS: PLEASE COMPLETE ALL PAGES OF THIS FORM

Careful completion of all sections of this form will help us to determine your eligibility and assist in vocational planning. In addition to employment, include trade/vocational training, special licenses, and related information. This information will be kept confidential.

Applicant/Client's Name
Date

SECTION I EDUCATIONAL/VOCATIONAL TRAINING

Check Highest Grade Completed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

☐ GED College ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

TRADE, VOCATIONAL, OR PROFESSIONAL INSTITUTIONS OF HIGHER EDUCATION ATTENDED:

School	Major Courses	Certificate/Degree
School	Major Courses	Certificate/Degree

MILITARY WORK EXPERIENCE OR TRAINING:	FOREIGN LANGUAGES:

SECTION II WORK EXPERIENCE

List Last Employer First – Include Volunteer Experience

Employer			Date Began
Address: Street	City	State	Date Ended
Name of Job			Wages

Can you still do this type of work?

☐ Yes ☐ No If not, why not?

Your Duties: *(Describe exactly what you did. List tools and equipment used.)*

Reason for leaving

What about your work did you like?

What did you dislike?

Employer			Date Began
Address: Street	City	State	Date Ended
Name of Job			Wages

Can you still do this type of work?
☐ Yes ☐ No If not, why not?

Your Duties: *(Describe exactly what you did. List tools and equipment used.)*

Reason for leaving

What about your work did you like?

What did you dislike?

Employer			Date Began
Address: Street	City	State	Date Ended
Name of Job			Wages

Can you still do this type of work?
☐ Yes ☐ No If not, why not?

Your Duties: *(Describe exactly what you did. List tools and equipment used.)*

Reason for leaving

What about your work did you like?

What did you dislike?

Employer			Date Began
Address: Street	City	State	Date Ended
Name of Job			Wages

Can you still do this type of work?
☐ Yes ☐ No If not, why not?

Your Duties: *(Describe exactly what you did. List tools and equipment used.)*

Reason for leaving

What about your work did you like?

What did you dislike?

SECTION III ADDITIONAL INFORMATION

List other jobs you have had:

Of all your jobs, which did you like the best?

Of all your jobs, which did you like the least?

What do you believe you need in order to become employed?

STATE OF CALIFORNIA DEPARTMENT OF REHABILITATION

CONSENT TO RELEASE AND OBTAIN INFORMATION

DR 260 (Rev. 01/18)

DIVISION: _____

Name / Entity / Address:	Individual's Full Name and Address:

Social Security Number: (if necessary)	Record Number:	Date of Birth:

I hereby consent to and authorize the Department of Rehabilitation (DOR) to:

☐ Obtain from the above Name / Entity ☐ Release to the above Name / Entity

☐ Benefits Planning Query
☐ Employment History
☐ HIV / AIDS Information
☐ Individualized Education Program (IEP)
☐ Individualized Plan for Employment (IPE)
☐ Psychological / Psychiatric Reports
☐ Benefits Summary and Analysis
☐ Financial Aid Award
☐ Progress Reports
☐ Transcripts / Report Cards
☐ Work Incentives Plan
☐ Vocational Rehabilitation Records
☐ Drug and Alcohol Information, as explicitly described below
☐ Regional Center Records, including Individual Program Plan (IPP)
☐ Other:

The dates of the requested information are: _____ to _____

I acknowledge and understand the following: the requested information may contain medical history, treatment, and diagnosed mental and physical condition, including drug and alcohol information, psychiatric disabilities, or HIV / AIDS. I may refuse to allow DOR to release or obtain information by not signing this form or not checking some of the above boxes, which may affect the provision of vocational rehabilitation services. The information requested by DOR will be used to determine eligibility for or assist in the provision of vocational rehabilitation services. The DOR shall not make any disclosure of the information received without my signed authorization, unless required or permitted by law. I may revoke this authorization in writing at any time; however, the revocation will not be effective to the extent that any person or entity has already acted in reliance on my authorization prior to the revocation. I may have a copy of this signed authorization, which will remain valid for 30 days from the date of signature, unless otherwise specified here: _____

Individual's Signature ✍	Date Signed
Guardian, Parent or Conservator Signature ✍	Date Signed
Witness Signature (if above signature by mark) ✍	Date Signed
Information sent To / From: Department of Rehabilitation	Phone Number:

Staff Name and Title:

Address:

CONSENT TO RELEASE AND OBTAIN INFORMATION

DR 260 (Rev. 01/18)

PRIVACY STATEMENT AND NOTICE

The California Information Practices Act of 1977 (Civ. Code § 1798.17) and the Federal Privacy Act (5 U.S.C. § 552a) require this notice be provided to individuals when collecting personal information. The information requested on this form, including the Social Security Number, is necessary to correctly identify the individual and provide written consent to obtain or release information for the limited purpose of determining eligibility for or assisting in the delivery of vocational rehabilitation services or release information at the individual's request. Please do not provide any personal information on this form that is not requested.

An individual has the right to revoke this authorization by providing written notice to the local Department of Rehabilitation (DOR) office serving the individual. If an individual revokes the authorization, it will not affect information already used or released before DOR received the individual's written notice. The federal Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 290dd-2) may not protect information after it is released or provided to agencies not covered by that law. Even though DOR is not subject to HIPAA, DOR adheres to applicable federal and state privacy laws. The DOR's Privacy Policy is online at www.dor.ca.gov.

Information obtained by DOR will be included in the individual's record of services. An individual has the right to inspect information maintained by DOR about the individual, unless otherwise prohibited or conditioned by law or regulation. For assistance accessing such information, contact the DOR staff listed on the form.

Any personal information collected or released by DOR is subject to the limitations established in federal and state law and regulations. Federal law requires DOR to release some personal information to other state agencies in order to match data, such as wage records, for federal performance accountability requirements. In some cases, DOR may release personal information in response to a court order, investigations in connection with law enforcement, fraud, abuse, or to protect the individual or others. The DOR may also release personal information for audit, evaluation, or research purposes directly connected with the administration of the vocational rehabilitation program or to significantly improve the quality of life for applicants and recipients of services in accordance with a written agreement that limits use of the information and safeguards confidentiality, and if the final product reveals any personal identifying information, informed, written consent is required. (29 U.S.C. § 3141; 34 C.F.R. § 361.38; 42 C.F.R. §§ 2.33, 2.51, 2.52, 2.61, and 2.63; Civ. Code §§ 56.13 and 1798 et seq.; and Cal. Code of Regs., tit. 9, §§ 7140 through 7143.5.)

If information is RELEASED with the informed, written consent of the individual to whom the information pertains, the receiving individual or agency should be aware that the information from DOR is confidential. Federal and state law and regulation prohibit any further disclosure of this information without the informed, written consent of the individual to whom this information pertains, unless otherwise permitted by law.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

(Check One)

☒ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

_____

Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.

2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.