Iowa Tribe of Oklahoma Vocational Rehabilitation Application

APPLICATION CHECKLIST:

(ANY WORKER STARTING AN APPLICATION WILL BE RESPONSIBLE FOR COMPLETION OF THAT APPLICATION.)

Documents Required:

1. __ **PROOF OF INCOME:** (include income for all family members)
   a. Social Security Award Letter or VA Award Letter
   b. Copy of Benefit Check(s)
   c. Income Verification from the Department of Human Services
   d. Wages
      i. Letter from Employer
         1. Must be on letterhead stationary or notarized
         2. Must include dates of employment and total gross wage for the month
      ii. Copy of Check Stubs
   e. Notarized Statement

2. __ **PROOF OF INDIAN DECENT**
   a. Tribal Membership/Enrollment Card
   b. Census Card or Letter of Agency

3. __ **PROOF OF SOCIAL SECURITY NUMBER**
   a. Social Security Card
   b. Driver's License

4. __ **PROOF OF MAILING ADDRESS/RESIDENTIAL VERIFICATION**
   a. Utility Bill
   b. Driver's License
   c. Rent Receipt
   d. Voter's Registration

5. __ **PROOF OF DISABILITY**
   a. Doctor's Statement (dated within 1 year of application date and Disability) and/or School Assessment Records
   b. Copy of Social Security Disability Check, Aid to Disable Check, VA disability check
   c. Copy of SSI Check if applicant is less than the age of 65

6. __ **COPIES OF:** __ FAFSA (Pell Grant), __ TRIBAL HIGHER ED. AWARD LETTER, __ PRIVATE SCHOLARSHIPS

Iowa Tribe of Oklahoma Rehabilitation Program Initial Application

Applicant Information

Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Tribal Affiliation:	County of Residence:	Sex:
Marital Status:	Total Number of Family Members Living in the Home:	
Finding Directions: _____ _____		
Are you a Veteran? Yes No (Please	Service Connected Disability?	
If yes, please list serial and dates of services:		

Employment Information (Last Three Jobs)

Current employer:		
Employer address:		Dates Employed To/From:
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Reason for Leaving: _____		
Previous employer:		
Employer address:		Dates Employed To/From:
Phone:	Email:	Fax:
City:	State:	ZIP Code:
Reason for Leaving: _____		
Previous employer:		
Employer address:		Dates Employed To/From:
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Reason for Leaving: _____		

Medical/Insurance Information

Do you have Medical/Hospital Insurance including Medicare & Medicaid? Yes No (Please Circle)			
If yes, please fill in the information below:			
Name:		Address:	
City:	State:	ZIP Code:	Policy/group Number:

Educational History

High School:		
City:	State:	Grade/Hrs. Completed:
Major:	Dates To/From:	

College:		
City:	State:	Grade/Hrs. Completed:
Major:	Dates To/From:	
Technical:		
City:	State:	Grade/Hrs. Completed:
Major:	Dates To/From	
Other:		
City:	State:	Grade/Hrs. Completed:
Major:	Date To/From:	

List Three People Who Will Always Know How to Locate You

1. Name:	
Address:	Phone:
Relationship:	
2. Name:	
Address:	Phone:
Relationship	
3. Name:	
Address:	Phone:
Relationship:	

Are you willing to move if employment is in another city? (Answer required)

_____

_____

_____

What is your disability and dates it occurred? (Answer required)

_____

_____

_____

How does your disability keep you from working? (Answer required)

_____

_____

_____

How can the Iowa Tribe Vocational Rehabilitation Program assist you? (Answer required)

_____

_____

_____

APPENDIX A. REHABILITATION SERVICES APPLICATION

My signature to this document constitutes an application for the ITOVR services. In order to affect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. All information, both medical and personal, given or made available to the agency shall be held confidential. Use of such information will be limited to purposes directly connected with the administration of my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended by Rehabilitation Amendments of 1992, Title 56.

Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Information will not be disclosed to any individual agency or organization without my written consent or that of my parent, guardian, or representative as applicable.

CONSUMER RIGHT AND REMEDIES

I have been advised of the availability of the Consumer Assistance Program (CAP) and have received a brochure explaining the purpose of CAP and the procedures for using CAP. I or my representative may call the CAP office for assistance at 1-800-522-8224.

I understand that I may request an informal administrative review or a formal appeal if I do not agree with a decision made by my counselor regarding furnishing or denial of Vocational Rehabilitation Services. A formal appeal may be requested by contacting the Director of the Iowa Tribe of Oklahoma Vocational Rehabilitation Program: Rose Malone, 335588 E. 750 Road, or Box 728, Perkins, OK 74059; or (405) 547-2402 ext. 248.

Consumer: _____ Date: _____

Parent/
Guardian/Rep.: _____ Date: _____

Counselor: _____ Date: _____

APPENDIX B. AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, SS # _____, DOB_____
(Consumer's Name)

authorize _____ Record # _____
(doctor, hospital, clinic, or school)

or its Director, designee or records department, to release information contained in my records to the individual or organization below:

1. Name and title of person's or organization to which disclosure is to be made:

   Iowa Tribe of Oklahoma Vocational Rehabilitation Program
   P.O. Box 728
   Perkins, OK 74059

   Ph. - 1 (888) 336-4692 or (405) 547-2402
   Fax – (4005) 547-1090

2. Specific type of information to be disclosed

   [ ] Medical [ ] Psychological [ ] Vocational [ ] Other

3. The purpose and need for such disclosure.
   - [ ] Established eligibility for such disclosure
   - [ ] Develop a vocation program for Consumer
   - [ ] Determine need for and/or type of treatment
   - [ ] Other (specify) _____

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION THAT COULD BE CONSIDERED INFORMATION ABOUT COMMUNICABLE OR VERNERAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFIENCY VIRUS, ALSO KNOWN AS AN AQUIRED IMMUNE DEFIENCY SYNDROME (AIDS).

NOTICE: INFORMATION IN YOUR RECORDS THAT ARE CONFIDENTIAL BY LAW AND CANNOT BE RELEASED WITHOUT YOUR PERMISSION EXCEPT IN LIMITED CIRCUMSTANCES INCLUDING RELEASE TO PERSONS WHO HAVE HARD RISK EXPOSURES. RELEASE FOR STATISTICAL OR EPIDEMOLOGICAL PURPOSES. WHEN SUCH INFORMATION IS RELEASE IT CANNOT CONTAIN INFORMATION FROM WHICH YOU COULD IDENTIFY UNLESS RELEASE OF THAT IDENTIFYING INFORMATION IS AUTHORIZED BY YOU, BY AN ORDER OF THE COURT OR THE DEPARTMENT OF HEALTH BY LAW.

4. This release may be revoked at any time and shall be valid no longer than is reasonably necessary to accomplish the purpose for which is given.
5. This release expires (12) twelve months following the date signed by me.

Consumer's Signature: _____ Date: _____
(Parent or Guardian)

Witnessed by: _____ Date: _____

APPENDIX C. STATEMENT OF INCOME AND LIABILITIES

1. A. Are you or a household member working full-time or part-time and earning money?

[ ] Yes [ ] No If yes, complete the following information:

Employed Person	Employment	Monthly Take Home Pay

B. Do you have transportation, if necessary for training or employment?

I certify that this information I have given is true, correct, and complete to the best of my knowledge. I agree to notify my Rehabilitation Program Counselor within 20 day if I have changes in my living arrangement, address, income, bank accounts, automobiles, property of any kind, and expenses or needs.

I understand that the information I have given will be carefully studied and that I might be asked to provide proof of the answers given. I further understand that any false statement make me subject to prosecution for fraud. I hereby authorize the Iowa Tribe of Oklahoma Vocational Rehabilitation Program (ITOVR) to make any necessary investigation to verify the information I have given.

When this form is returned, the ITOVR will review the information and discuss the services that can be provided and determine the amount of financial participation.

_____ _____

Consumer/Representative Date

IOWA TRIBE VOCATIONAL REHABILITATION PROGRAM
GENERAL HEALTH CHECKLIST

Full Name_____ Case # _____

Counselor _____ DOB _____ Height _____ Weight _____

Please circle YES or NO if you have any of the following symptoms or conditions:	**Has it kept you from working?** (Please check the box accordingly) **Yes**	**No**
1. A disorder of eyes, ears, nose, or throat? **YES** or **NO**		
2. Frequent dizziness, fainting, headaches, seizures, convulsions, paralysis, or stroke? **YES** or **NO**		
3. A mental or nervous disorder? **YES** or **NO**		
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of the lungs? **YES** or **NO**		
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorders of the heart or blood vessels? **YES** or **NO**		
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gall bladder? **YES** or **NO**		
7. Disorder of kidneys, bladder, prostate, or reproductive system? **YES** or **NO**		
8. Diabetes, thyroid, or other endocrine disorders? **YES** or **NO**		
9. Arthritis, or other disorder of the muscles or bones, including spine, back or joints? **YES** or **NO**		
10. Absence of amputation of any body part? **YES** or **NO**		
11. Loss of use of arms or legs, or other body parts? **YES** or **NO**		
12. A tumor, cancer, or disorder of the lymph glands? **YES** or **NO**		
13. Allergies? **YES** or **NO**		
14. Anemia or other disorder of the blood? **YES** or **NO**		
15. Excessive use of alcohol or any habit forming drugs? **YES** or **NO**		
16. Any other physical or mental condition? **YES** or **NO**		

If you answered **YES** to Question 16, please specify: _____

_____

_____

IOWA TRIBE VOCATIONAL REHABILITATION PROGRAM
GENERAL HEALTH CHECKLIST (cont.)

Name and address of your personal physician/clinic: (If none, please state so):

_____

_____

_____

PLEASE ANSWER THESE QUESTIONS FOR ANY CONDITIONS MARKED **"YES"** ON THE PREVIOUS PAGE.

Have you been or are being treated for any of these conditions? [ ] Yes [ ] No

If yes, which conditions? _____

_____

_____

Have you been hospitalized for any of these conditions? [ ] Yes [ ] No

If yes, under what conditions? _____

_____

_____

Are you taking any medications? [ ] Yes [ ] No

If yes, list medications: _____

_____

_____

Do you have any restrictions from these conditions? [ ] Yes [ ] No

If yes, what restrictions: _____

_____

_____

To the best of my knowledge, what I have said is true and I have not withheld any information.

_____ _____

(Date) (Signature of Consumer)

Person who provided information, if not applicant: _____

Certification of Eligibility for Federal Assistance in Certain Programs

I, understand that 34 CFR 75.60, 75.61, and 75.62 require that I make specific certification of eligibility to the U.S. Department of Education as a condition of applying for Federal funds in certain programs and that these requirements are in addition to any other eligibility requirements that the U.S. Department of Education imposes under program regulations.

Under 34 CFR 75.60-75.62:

I certify that:

A. **I do not owe a debt, or I am current in repaying a debt, or I am not in default (as that item used at 34 CFR Part 668) on a debt.**

1. To the Federal Government under a nonprocurement transaction (e.g., a previous loan, scholarship, grant, or cooperative agreement):

2. For a fellowship scholarship, stipend, discretionary grant, or loan in any program of the U.S. Department of Education that is subject to 34 CFR 57.50, 75.61, and 75.62, including:

- Federal Pell Grant Program (20 U.S. 107a, et seq)
- Federal Supplemental Educational Opportunity Grant (SEOG) Program (20 U.S. 1070 (b), et seq)
- State Stafford incentive Grant Program (SSIG) 20 U.S. 1070c, et seq
- Federal Perkins Loan Program (20 U.S.C. 1087aa, et seq)
- Income Contingent Direct Loan Demonstration Project (20 U.S.C. 1087a, note):
    - Federal Stafford Loan Program, Federal Supplemental Loans for students [SLS], Federal PLUS, or Federal Consolidation Loan Program (20 U.S. 2601, et seq)
- Cuban Student Loan Program (20 U.S.C. 2601, et seq)
- Robert C. Byrd Honors Scholarship Programs (20 U.S.C. 1070d-31, et seq)
- Jacob K. Javits Fellowship Program (20 U.S.C. 1134h-1134)
- Patricia Roberts Harris Fellowship Program (20 U.S.C. 1134h-1134)

- Christa McAuliffe Fellowships Program (20 U.S.C. 1105-1105j)
- Bilingual Education Fellowship Program (20 U.S.C. 3321-3262)
- Rehabilitation Long Term Training Program (29 U.S.C. 774(b))
- Paul Douglas Teacher Scholarship Program (20 U.S.C. 1104, et seq)
- Law Enforcement Education Program (42 U.S.C. 3775)
- Indian Fellowship Program (29 U.S.C. 774 (b))

B. **I have made arrangements satisfactory to the U.S. Department of Education to repay a debt as describes in A.1 or A.2 (above) on which I had not been current in repaying or know which I was in default (as that term is used in 34 CFR Part 668).**

C. **I certify also that I have not been declared by a judge, as a condition of sentencing under section 5301 of the Anti-Drug Abuse Act of 1988 (21 U.S.C. 862), ineligible to receive Federal assistance for the period of this requested funding.**

I understand that providing a false certification to any of the statements above makes me liable for repayment to the U.S. Department of Education for fund received on the basis of this certification, for civil penalties, and for criminal prosecution under 18 U.S.C. 1001.

_____ _____

(Consumer Signature) (Date)

_____

(Typed or Printed Name)

Contacts

Main Office

Physical Address: 335588 E. 750th Road
P.O. Box 728
Perkins, OK 74059

Phone: 405-547-2402
Toll Free: 1-888-336-IOWA (4692)

Fax: 405-547-1090

ITOVR	ITOVR	ITOVR
Rose Malone, Director	**Ron Baker, Counselor**	**Christa Tsotaddle, Transitional Counselor**
Ext. 248	**Ext. 245**	**Ext. 168**

Satellite Office

CPN Employment & Training
Rowana Condry, Counselor
300 East Walnut
Tecumseh, OK 74873

Ph.: 405-598-0797
Toll Free: 1-800-880-9880

Fax: 405-598-6273

Iowa Tribe of Oklahoma
Vocational Rehabilitation Program
335588 E. 750th Road
Perkins, OK 74059
405-547-2402

CERTIFICATION OF INTENT TO PURSUE EMPLOYMENT

I am applying for services with the Iowa Tribe Vocational Rehabilitation Program. I understand I must have a documented physical or mental disability that causes an impediment to attaining and/or maintaining gainful employment.

I understand that in order to be eligible for this program and receive services, I must intend to work progressively toward attaining/maintaining suitable employment. I understand that all services provided by this program are for the sole purpose of retaining/obtaining EMPLOYMENT.

I certify that it is my full intent to work with my Rehabilitation Counselor to establish an Individualized Plan of Employment that will outline the goals and objective I need to meet in order to retain/obtain suitable EMPLOYMENT.

I understand that AFTER I retain/obtain employment, I will be expected to provide my Rehabilitation Counselor with information regarding the wages I am earning, name, and address of employer, and the date of employment. I understand that this information will be used to for statistical/reporting purposes only. I understand that my personal information will NOT be revealed without my written permission.

_____ _____
Consumer Signature Date

_____ _____
Rehabilitation Counselor Date

IOWA TRIBE OF OKLAHOMA VOCATIONAL REHABILITATION PROGRAM

Consumer Responsibilities

To make the rehabilitation effort a success, the consumer and the ITOVR staff must work together to reach chosen goals. This shared responsibility requires that the consumer or applicant for services accept the basic responsibilities listed below. It is the counselors' responsibility to fully and appropriately inform the consumer of consumer responsibilities.

1. **Keep appointments for medical examinations and evaluations.**
2. **Follow the advice of doctors and other licensed treatment professionals.**
3. **Take an active part in developing the Individualized Plan for Employment (IPE).**
4. **Provide enrollment documents, FAFSA submission conformation letter, Tribal award letter and letters of all scholarships received.**
5. **Attend training classes on a regular basis.**
6. **Take part in regular reviews (at least once a year) of the Individualized Plan for Employment (IPE); also take part all in amendments to the program.**
7. **Maintain satisfactory progress toward completing the IPE.**
8. **Must abstain from abuse of drugs and/or alcohol. Individuals who abuse drugs and/or alcohol while receiving services will be referred to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and/or appropriate agencies for purposes of seeking treatment. All case services will be suspended. If the consumer refuse or fails to cooperate with seeking treatment, or is not available to pursue a DRS program, this will be considered as reasonable cause for case closure.**
9. **Inform ITOVR staff of any changed in address, financial status and any other program related changes.**
10. **Apply for and make appropriate use of any comparable benefits and services for which the consumer is eligible to defray in whole or in part the cost of services in the consumer's IPE and provide verifications of financial aid award status to counselor.**
11. **Working with the counselor to obtain suitable gainful employment or appropriate independent living outcomes as services are being completed.**
12. **Consumer must submit resume upon request by VR counselor.**

I, the consumer, agree to practice the above responsibilities for acceptance of receiving services from the Iowa Tribe of Oklahoma Vocational Rehabilitation Program.

Consumer Signature: _____ Date: _____

Consumer Signature: _____ Date: _____

[ ] copy given to consumer