APACHE TRIBE OF OKLAHOMA
Vocational Rehabilitation Program
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ATVR STAFF

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APPLICATION FOR SERVICES

1. I am applying for services with the Apache Tribe Vocational Rehabilitation (ATVR) Program. I understand that in order to receive vocational rehabilitation services, I must have:

   a. A physical and/or mental disability which interferes with my ability to work.
   b. There exists a reasonable expectation that I will benefit from services in terms of employability or self-sufficiency.
   c. Require Vocational Rehabilitation services to prepare for, enter or retain gainful employment.

   I understand that in applying for services, I am entitled to an evaluation of my eligibility for services.

2. If I am found eligible, I understand that my counselor will involve me in planning my Individualized Plan of Employment (IPE) and that my IPE will be reviewed at least once each year. Similar benefits and referral to other agencies will also be used to assist me in completing my IPE. I understand that I must keep all scheduled appointments.

3. **I understand that Vocational Rehabilitation services are dependent upon the availability of ATVR Program funds. A referral may be made to the Oklahoma Department of Rehabilitation Services Agency, and/or other American Indian Vocational Rehabilitation Programs for rehabilitation assistance.**

4. I am aware that I have the right to appeal decisions made by the Apache Tribe Vocational Rehabilitation Program staff by requesting a meeting with the Program Director in writing within 30 days of the effective date of the decision. I also understand that I may continue to appeal any grievance beyond the Program Director level to a hearing officer. I must make the request to the hearing officer in writing addressed to the ATVR office, within 30 days of the Program Director's decision.

5. I understand that all information will be treated in a confidential manner

THIS FORM HAS BEEN <u>REVIEWED WITH ME</u> AND I HAVE BEEN GIVEN A COPY OF IT.

Original /Consumer's file
Copy/Consumer's copy

APACHE TRIBE OF OKLAHOMA
VOCATIONAL REHABILITATION PROGRAM
REHABILITATIVE/VISUAL SERVICES

CLIENT INFORMATION

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

HOME
ADDRESS: _____
(Street, Route, or P.O. Box) (City) (State) (Zip)

FINDING
DIRECTIONS: _____

COUNTY: _____

TELEPHONE
NUMBER: _____ Cell/Message #: _____
(Home)

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SEX: [ ] MALE [ ] FEMALE

MARITAL STATUS: [ ] Never Married [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

ENROLLED TRIBE: _____ (CDIB) [ ] YES [ ] NO

TOTAL NUMBER OF FAMILY IN THE HOME: _____

GUARDIAN NAME: _____
(If Applicable) (Last) (First) (Middle)

WHAT IS YOUR DISABILITY AND HOW DOES IT LIMIT YOUR ABILITY TO WORK?

_____

_____

_____

_____

_____

_____

_____

_____

HAVE YOU BEEN SEEN BY A DOCTOR FOR PROBLEMS RESULTING FROM YOUR DISABILITY?

[ ] YES [ ] NO

If yes, list

(1)_____

(Dr. name and address) (Dr. telephone number)

_____

(Dates seen by the Dr.) (Reason seen)

(2)_____

(Dr. name and address) (Dr. telephone number)

_____

(Dates seen by the Dr.) (Reason seen)

(3)_____

(Dr. name and address) (Dr. telephone number)

_____

(Dates seen by the Dr.) (Reason seen)

DO YOU HAVE PRIVATE MEDICAL/HOSPITAL INSURANCE AND/OR MEDICARE AND MEDICAID?

[ ] Yes List type, company name, address, and policy/group or case number:

[ ] No List reason:

_____

ARE YOU A VETERAN? [ ] Yes [ ] No

If yes, list serial number and dates of service:

_____

DO YOU HAVE A SERVICE CONNECTED DISABILITY? [ ] Yes [ ] No

If yes, specify:

_____

_____

SOCIAL SECURITY:

SSI Status:_____ SSDI Status:_____

[0=Not and Applicant, 1=Applicant Allowed Benefits, 2=Applicant Denied Benefits, 3=Status of Application Pending, 4=Not Known If Applicant, 5=Benefits Discontinued Prior to Application]

Work Status: _____

Hours Worked in Week Prior to Application:_____ Earnings in Week Prior to Application: $ _____

LIST THE MEMBERS OF YOUR IMMEDIATE HOUSEHOLD WITH EMPLOYMENT AND INCOME INFORMATION

Name	**Relationship**	**Employer**	**Weekly Hours**	**Weekly Net Salary**

DO YOU HAVE MEDICAL /HOSPITAL INSURANCE THROUGH YOUR EMPLOYER?

[ ] Yes List type, company name, address and policy group number:

[ ] No list reason:

WHO REFERRED YOU TO OUR OFFICE?

LIST ANY OTHER INCOME (SSI, Social Security, Public Assistance, Worker's Comp. etc.):

Source	Amount	Case Number	Time Received

HAVE YOU EVER APPLIED FOR REHABILITATIVE OR VISUAL SERVICES?

[ ] Yes When? [ ] No

HAVE YOU EVER DEFAULTED ON A STUDENT LOAN? [ ] Yes [ ] No

Highest Grade Completed _____ **Special Education** ___Yes or ___No

***LIST YOUR EDUCATION HISTORY*:**

HIGH SCHOOL

(NAME) (CITY/STATE)

(GRADE/HRS. COMPLETED) (MAJOR) (DATES)

COLLEGE

(NAME) (CITY/STATE)

(GRADE/HRS. COMPLETED (MAJOR) (DATES)

TECHNICAL

(NAME) (CITY/STATE)

(GRADE/HRS. COMPLETED (MAJOR) (DATES)

OTHER

(NAME) (CITY/STATE)

(GRADE/HRS. COMPLETED (MAJOR) (DATES)

LIST YOUR LAST THREE JOBS:

(JOB TITLE) EMPLOYER NAME AND ADDRESS WEEKLY SALARY

(DATES EMPLOYED) (REASON FOR LEAVING) (Phone #)

(JOB TITLE) EMPLOYER NAME AND ADDRESS WEEKLY SALARY

(DATES EMPLOYED) (REASON FOR LEAVING) (Phone #)

(JOB TITLE) EMPLOYER NAME AND ADDRESS WEEKLY SALARY

(DATES EMPLOYED) (REASON FOR LEAVING) (Phone #)

LIST THREE PEOPLE WHO WILL ALWAYS KNOW HOW TO LOCATE YOU:

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Name:_____ Relationship:_____

Address:_____ Telephone:_____

WHAT SERVICES DO YOU NEED?

CLIENTS RIGHTS AND REMEDIES

If I have questions or concerns about the administration of my rehabilitation program, I may call the Apache Tribe Vocational Rehabilitation at 405-247-7494

I have been advised of the availability of the Client Assistance Program (CAP) and have received a brochure explaining the purpose of the CAP and procedures for using CAP. I or my representative may call the CAP office for assistance at 405-822-8224.

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. An informal administrative review may be requested by contacting my counselor. A formal appeal may be requested by contacting the Director of the Apache Tribe Vocational Rehabilitation Program at 510 E. Colorado or P.O. Box 1330, Anadarko, Oklahoma 73005.

My signature to this document constitutes an application for rehabilitation services. In order to effect 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 to be 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 1998. **Failure to provide this information may prevent the Rehabilitation Program 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.