# Delaware Nation

## Vocational Rehabilitation Program

P.O. Box 546 • Anadarko, OK 73005
Phone: (405) 247-5873 • Fax: (405) 247-2360 • Toll Free: 1 (866) 435-5873

Dear Applicant,

Thank you for your interest in the Delaware Nation Vocational Rehabilitation program (DNVRP). DNVRP is designed to help individuals with disabilities to become or remain employed in a job that is compatible with their disability or disabilities. All services must be geared toward this goal. If you are found eligible you will meet with a Vocational Rehabilitation (VR) counselor to develop an Individualized Plan for Employment (IPE) outlining your needs and how those will be addressed in order to help you become employed in an appropriate position.

Please complete the enclosed application as thoroughly as possible. If you have any questions about the needed information, please contact our office or ask your counselor when you come in for your initial appointment. The more information you include, the quicker we are able to determine your eligibility and/or the services you might need. Included are several forms. The Authorization of Release is important if we need to request information from your doctor(s) or you give us permission to share information with other agencies or people. The General Health Checklist helps us to learn more about what your conditions are and how they affect your ability to work. The Documentation of Disability is very helpful. Please have your medical or psychological health professional to complete this for us, if possible. You will also find information about the Client Assistance Program (CAP}.

Please include all the items included on the Documentation Checklist when you return your application. Please do not date your application until you are ready to submit it.

If you are determined eligible and are involved with any other program that is providing services, such as through your tribe or through the state's VR program (DRS), please let us know so we can be sure we are all working together to help you reach your employment goal. In some instances there are programs that can cover certain things the DNVRP is unable to and we may be able to help with things they are not able to.

# Delaware Nation
## Vocational Rehabilitation Program
## Required Document Checklist

Applicant must provide at least one form of documentation for each of the following areas Indicated.

**DOCUMENTS REQUIRED:**

1. ____ **PROOF OF INCOME** (Include all Income for all household members)
   - A. Social Security Award Letter or VA Award Letter
   - B. Copy of benefits check(s)
   - C. Income verification from the Department of Human Services (OHS) or a letter stating what services you are receiving
   - D. Wages (either #1 or #2)
     1. Letter from employer
        - a. Must be on letterhead stationary or notarized
        - b. Must Include dates of employment, average hours worked per week and gross wages for the month
     2. Copy of most recent check stub

2. ____ **PROOF OF TRIBAL ENROLLMENT**
   - A. CDIB Card with roll number & which tribe you are enrolled in
   - B. Tribal membership card
   - C. Census card or letter from your tribe or BIA proving enrollment or Indian Preference for hiring purposes

3. ____ **PROOF OF AGE**
   - A. CDIB
   - B. Tribal membership card
   - C. Driver's license or state-Issued ID
   - D. Military-issued ID

4. ____ **PROOF OF SOCIAL SECURITY NUMBER**
   - A. Social Security card
   - B. Letter or document from the Social Security Administration stating your social security number
   - C.Tribal enrollment verification with your social security number included
   - D. Military-Issued ID with your social security number included

5. ____ **PROOF OF MAILING ADDRESS/RESIDENTIAL VERIFICATION**
   - A. Utility bill in your name. This can be gas or electric, but not phone, cell phone, Internet or cable
   - B. Driver's license or state-Issued ID with your current address
   - C. Rent receipt or lease In your name including your current address
   - D. Voter's registration card
   - E. Completed DNVRP residence form showing who you live with as well as one of the above In their name

# Delaware Nation
## Vocational Rehabilitation Program
## Required Document Checklist

6. ____ **PROOF OF DISABILITY**

A. Doctor's or other relevant professional's statement (verifying disability and limitations) within the last year

8. School Assessment records

C. Copy of SSDI check, Aid to Disabled check, VA Disability check or SSI check (please note that additional details will likely be needed to show that you can work with help from VR services)

D. Completed DNVRP Documentation of Disability form from the appropriate professional

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## APPLICATION FOR SERVICES

1. I am applying for services from the Delaware Nation Vocational Rehabilitation Program (DNVRP).

   I understand that in order to receive Vocational Rehabilitation (VR) services, I must have:
   a. A physical or mental disability which interferes with my finding a job, and
   b. A reasonable chance to be able to work after I receive VR services.

   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 the development of my VR plan and my program will be reviewed at least once a year. Similar benefits and referral to other agencies will also be used to assist me in meeting my VR plan. I understand that I must keep scheduled appointments.

3. I understand that VR services are dependent upon the availability of openings at the DNVRP and upon availability of funds and openings with the state agency for rehabilitation assistance.

4. I am aware that I have the right to appeal decisions made by the DNVRP staff by requesting a meeting with the Program Coordinator verbally or in writing within 3days of the of the effective date of the decision. I also understand that I may continue to appeal any grievance beyond the Program Coordinator's level provided that I make this request within 30 days of the Program Coordinator's decision.

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

**TH1S FORM HAS BEEN REVIEWED WITH ME AND I HAVE BEEN GIVEN A COPY.**

_____ _____

Applicant's Signature
(Parent or guardian, if applicable)

Date

# Delaware Nation
## Vocational Rehabilitation Program

## Consumer Information

**Name:** _____
(Last) (First) (Middle)

**Social Security Number:** _____

**Telephone Number:** (_____) _____ (_____) _____
(Home) (Alternate)

**E-mail:** _____

**Date Of Birth:** _____ **Sex:** ☐ Male ☐ Female

**Marital Status:** ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated

**Indian Tribe:** _____ **CDIB:** ☐ Yes ☐ No

**Total Number of Family In The Home:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Finding directions**: _____

**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, please list:

Doctor's Name and Address | Doctor's Telephone Number

Dates seen by Doctor | Reason Seen

Doctor's Name and Address | Doctor's Telephone Number

Dates seen by Doctor | Reason Seen

Doctor's Name and Address | Doctor's Telephone Number

Dates seen by Doctor | Reason Seen

**DO YOU HAVE PRIVATE MEDICAL/HOSPITAL INSURANCE, MEDICARE AND/OR 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: _____

**SSI/SSDI STATUS**

SSI Status: _____ SSDI Status: _____

(O = Not an Applicant, I = Applicant Allowed Benefits, 2 = Applicant Denied Benefits,3 = Status of Application Pending, 4 = Not Known If Applicant, 5 = Benefits Discontinued Prior to Application)

**EDUCATION**

Highest Grade Completed: _____ Special Education Student: ☐ Yes ☐ No

**WORK STATUS**

Current Work Status: ☐ Employed ☐ Currently Unemployed

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

**DO YOU HAVE MEDICAL/HOSPITAL INSURANCE THROUGH YOUR EMPLOYER?**

☐ YES List type, company name, address, and policy/group or case number:

_____

_____

☐ NO List reason: _____

**HOW WERE YOU REFERRED TO OUR OFFICE?** _____

**LIST MEMBERS OF YOUR IMMEDIATE HOUSEHOLD WITH EMPLOYMENT AND INCOME INFORMATION:**

| Name | Relationship | Employer | Weekly Hours | Weekly Net Salary |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

Source Amount Case Number Time Received

_____

_____

_____

_____

**HAVE YOU EVER APPLIED FOR REHABILITATIVE OR VISUAL SERVICES?**

☐ **YES If so, when? _____** ☐ **NO**

**HAVE YOU EVER DEFAULTED ON A STUDENT LOAN?** ☐ **YES** ☐ **NO**

**LIST YOUR EDUCATION HISTORY:**

**HIGH SCHOOL:**

_____

Name of School Address City/State

_____

Grade/Hours Completed Dates

**COLLEGE:**

_____

Name of College/University Address City/State

_____

Grade/Hours Completed Major Dates

**TECHNICAL:**

_____

Name of Institution Address City/State

_____

Grade/Hours Completed Major Dates

**OTHER:**

Name of Institution | Address | City/State

Grade/Hours Completed | Major | Dates

**LIST YOUR LAST THREE JOBS:**

Employer | Address | City/State

Dates Employed | # of HRS/WK | Reason for Leaving

Employer | Address | City/State

Dates Employed | # of HRS/WK | Reason for Leaving

Employer | Address | City/State

Dates Employed | # of HRS/WK | Reason for Leaving

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

**(1) Name:** _____ **Relationship** _____

**Address:** _____
Street or Rte # City State ZIP

**Telephone:** _____ **E-mail:** _____

**(2) Name:** _____ **Relationship** _____

**Address:** _____
Street or Rte # City State ZIP

**Telephone:** _____ **E-mail:** _____

**(3) Name:** _____ **Relationship** _____

**Address:** _____
Street or Rte # City State ZIP

**Telephone:** _____ **E-mail:** _____

**Do you participate in Native American Indian Ceremonial Activities? If so, what?**

_____

_____

_____

**This is confidential information and no penalty will be inflicted for your answers.**
**WHAT SERVICES DO YOU NEED? (Use additional pages or back of page, if necessary.)**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

# Delaware Nation

## Vocational Rehabilitation Program

### AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

### I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WiIl BE SHARED)

Name Date of Birth

Address City

State ZIP Area Code & Telephone Number

### II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information Is Information that Identifies me. The purpose of this authorization Is to allow _____ to share my protected health Information.

If this box is checked, I authorize the Delaware Nation Vocational Rehabilitation Program to share my PHI with the Delaware Nation Executive Committee, as needed, for complaint investigation and And administration of the program. I understand this authorization is optional, and other steps must be taken to resolve a complaint prior to the Executive Committee's involvement. Further, I understand sharing of information with the Executive Committee may include information about my disability services requested or received and other personal information information included in my case file. _____ _____

Initials Date

### III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize _____ as set forth below, to share my protected health information for reasons In addition to those already permitted by law.

A. Persons/Organizations receiving Information and purpose for sharing

Name, Address, Phone & Fax, Patient ID # (if applicable) Relationship

# Delaware Nation

## Vocational Rehabilitation Program

### AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

**B. Information to be shared**

**1. Specific Information to be shared (check one or more boxes below).**

☐ Medical ☐ Psychological ☐ Vocational

☐ Other (specify) _____

**2. The purpose and need for such disclosure:**

☐ Establish eligibility for rehabilitation services

☐ Develop a vocational plan for client

☐ Determine need for and/or type of treatment

3. The Information I authorize may Include information that could be considered information about communicable or non communicable which may Include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS) (Statute 63 O.S. 1-502-2[B1). I understand that information in my records that I have a communicable or non-communicable disease is made confidential by law and cannot be released without my permission except In limited circumstance Including release to persons who have had risk of exposures. When such Information Is released It cannot contain information from which I can be identified unless release of that Identifying Information Is authorized by me, by an officer of the court or the Department of Health by law. I understand that these records may Include psychiatric, alcohol and drug abuse Information, occupational Information or Information regarding other Insurance coverage.

# Delaware Nation

## Vocational Rehabilitation Program

### AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

**IV. EXPIRATION & REVOCATION**

A. This authorization will expire (must choose one):

☐ 12 months from the date signed in Part V.

☐ Other (Insert date or event): _____

B. Right to revoke

I understand I may change this authorization at any time by submitting a written request to the Delaware Nation Vocational Rehabilitation Program Coordinator . I understand I cannot restrict Information that may have already been shared based on this authorization.

V. SIGNATURES

This document must be signed by the Individual's legal representative .

_____

Signature (Patient or Legal Representative) Date

_____

Printed Name (Patient or Legal Representative) Capacity of Legal Representative (If applicable)

# Delaware Nation

## Vocational Rehabilitation Program

Consumer ID II _____ VR Counselor _____

**DOCUMENTATION OF DISABILITY**

Name: _____ Date of Birth _____ SSN#_____

Dear Doctor :

The above individual has submitted an application for rehabilitation services. In order to assist the applicant, I am required by Federal law to verify that this individual has a substantial disability which results in an impediment to employment .

I am mandated by Federal law and Department Policy to determine this individual's eligibility within sixty (60) days. Therefore, I am asking for your assistance on providing answers to the following questions:

(1) Diagnosis: Please describe the disabling condition(s) and supply the appropriate diagnosis, including diagnostic codes (either ICD-9 or DSM-IV codes). _____

_____

_____

(2) Prognosis: _____

(3) Recommendation(s) for treatment: Can this individual's condition be improved through treatment?

Yes ☐ No ☐ Unknown ☐ If yes, what type of treatment is recommended?

_____

(4) Functional Limitation(s): Please list all limitations and restrictions created by this disability.

_____

_____

(5) Recommendations for individual's vocational rehabilitation plan: _____

_____

_____

# Delaware Nation

## Vocational Rehabilitation Program

Consumer ID II _____ VR Counselor _____

**DOCUMENTATION OF DISABILITY**

Thank you very much for your assistance.

• Physician Signature : _____ Date: _____

Physician Name (Please Print) _____

VR Counselor Signature : _____ Date: _____

• A mental health professional may also fill out this form for a psychological disability .

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## CONSUMER RESPONSIBILITIES

To make the rehabilitation effort a success, a Consumer and V .R. Counselor and/or Job Developer must work together to reach chosen goals. This shared responsibility requires that the consumer accept these basic responsibilities:

l. Threats (physical or verbal): DNVRP has a right to refuse and/or terminate services.
2. Keep appointment for medical examinations and other evaluations.
3. Follow the advice of doctors and other licensed treatment professionals.
4. Take an active part in developing the Individualized Plan for Employment (IPE).
5. Attend training classes on regular basis.
6. Take part in regular reviews (at least once a year) of the Individualized Plan for Employment (IPE). Also take part in any revisions to the program.
7. Maintain satisfactory progress toward completing the rehabilitation program .
8. Keep the V .R. Counselor informed of changes in the consumer's address, financial scat us, or other program related changes.
9. Apply for and use any comparable benefit s and services for which the consumer is eligible to defray in whole or in part the cost of services in the IPE.
10. Working with the Counselor and/or Job Developer to obtain suitable gainful employment.

_____ _____

Consumer Signature Date

_____ _____

Counselor Signature Date

# Delaware Nation
## Vocational Rehabilitation Program

### GENERAL HEALTH CHECKLIST

NAME _____ SS # _____ CSLR _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

Please answer "YES" or "NO" to all Items In each row.

| | | | | | If yes, has it kept you from working | |
|---|---|---|---|---|---|---|
| | | **Yes** | **No** | | **Yes** | **No** |
| **Do you have ……** | | | | | | |
| 1. A disorder of eyes, ears, nose or throat? …… | | ☐ | ☐ | | ☐ | ☐ |
| 2. Frequent dizziness, fainting, headaches seizures, convulsions, paralysis or stroke? …… | | ☐ | ☐ | | ☐ | ☐ |
| 3. A mental or nervous disorder? …….. | | ☐ | ☐ | | ☐ | ☐ |
| 4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis or other disorder of the lungs? …… | | ☐ | ☐ | | ☐ | ☐ |
| 5. Chest pain, high blood pressure, rheumatic, fever, heart murmur or other disorder of the heart or blood vessels? …… | | ☐ | ☐ | | ☐ | ☐ |
| 6. Intestinal bleeding, ulcers, hernia, colitis, other disorder of the stomach, intestines, liver or gallbladder? …… | | ☐ | ☐ | | ☐ | ☐ |
| 7. Disorder of kidney, bladder, prostate or reproductive system? …… | | ☐ | ☐ | | ☐ | ☐ |
| 8. Diabetes, thyroid problems or other endocrine disorders? …….. | | ☐ | ☐ | | ☐ | ☐ |
| 9. Arthritis or other disorder of the muscles or bones, Including the spine, back or joints? …….. | | ☐ | ☐ | | ☐ | ☐ |
| 10. Loss of use of arms, legs, or any body part? …… | | ☐ | ☐ | | ☐ | ☐ |
| 11. Absence or amputation of any body part? …… | | ☐ | ☐ | | ☐ | ☐ |
| 12. A tumor, cancer or disorder of the skin or lymph nodes? | | ☐ | ☐ | | ☐ | ☐ |
| 13. Allergies …….. | | ☐ | ☐ | | ☐ | ☐ |
| 14. Anemia or any other disorder of the blood? …… | | ☐ | ☐ | | ☐ | ☐ |
| 15. Addiction to or excessive use of alcohol or any habit forming drugs? …….. | | ☐ | ☐ | | ☐ | ☐ |
| 16. Any other physical or mental condition? ..... | | ☐ | ☐ | | ☐ | ☐ |

17. If you answered yes to #16, please specify _____

_____

18. Have you been or are you being treated for any of these conditions? ☐ YES ☐ NO

If NO, why not? _____

| If YES, | Condition | Who treated you? | When? |
|---|---|---|---|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

19. Have you ever been hospitalized for any of these conditions? ☐ YES ☐ NO

| If YES, | Condition | Where? | When? |
|---|---|---|---|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

20. Are you taking any medications? ☐ YES ☐ NO

| If YES, | Condition | Which medicines? |
|---|---|---|
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

21. Do you have any restrictions from these conditions? ☐ YES ☐ NO

| If YES, | Condition | What restrictions? |
|---|---|---|
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

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

_____ _____

Signature of Applicant Date

Person who provided information, if not applicant: _____

Comments:

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Please observe our office schedule:

**Mondays, Tuesdays, and Thursdays - <u>Appointment Days</u>**

No appointments after 3:00 PM unless authorized by counselor.

**Wednesdays - <u>Walk-in Day</u>**

For existing cases only. New applicants must turn in their application and await a call from their counselor to schedule their intake appointment.

ADRIAN----8:00-11:30 & 1:30-4:00 only

**Fridays - <u>Administrative Day</u>**

Counselors will handle all paperwork necessary to keep your case open and going. You will not be able to meet or speak with them as they tend to administrative duties.

**If you have a general question that doesn't require your counselor, or you just need to drop something off, please feel free to call or drop by and speak with the Administrative Assistant/VR Technician.**

Thank you,

DNVRP Staff

# Client Assistance Program
# CAP works with YOU!

## Office of Disability Concerns

The Office of Disability Concerns provides service under the Client Assistance Program **(CAP)** serving as a vital link between the Oklahoma Department of Oklahoma Rehabilitation Services (OKDRS) and the disability community. **CAP** provides advocacy to persons with disabilities who are seeking or receiving vocational rehabilitation (VR) services from DRS, as well as individuals who are receiving services from independent living centers or other Rehabilitation Act funded programs such as Tribal VR and Higher Education.

**CAP** is an independent advocate for clients and client applicants.

**CAP** was established to improve communication and help resolve issues between client and vocational rehabilitation/DR staff and other Rehabilitation Act funded program staff.

**CAP** also helps client understand the rehabilitation process and the benefits available under the Rehabilitation Act of 1973. **CAP**'s role is to provide information about benefit available under the Rehabilitation Act and to assist client with understanding their rights and responsibilities in relation to receipt of these benefits.

Additionally, **CAP** ensures that clients' rights are protected under the Rehabilitation Act.


Office of Disability Concerns
Client Assistance Program
2401 NW 23rd St.
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www.ok.gov/odc/C.A.P./
CAP@odc.state.ok.us
Friend Us on Facebook!