



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
- B. 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 3 days 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.

THIS 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?

SSI/SSDI STATUS

SSI Status: _____ SSDI Status: _____

(O = Not an 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)

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: _____

Delaware Nation

Vocational Rehabilitation Program

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL 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 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 included in my case file.

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 _____

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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.

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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:

1. 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 status, or other program related changes.
9. Apply for and use any comparable benefits 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:

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.

Suite90

Oklahoma City, OK 73107

Toll Free: (800) 522-8224

(405) 522-8224

[www.ok.gov/odc/C.A.P./](http://www.ok.gov/odc/C.A.P/)

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