Main Office Contact Information

Office Phone: (405) 422-7617

Email: CAAIVR@cheyenneandarapaho-nsn.gov

Fax: (405) 422-8213

Address: 100 Red Moon Circle – Annex Building

P. O. Box 167

Concho, Oklahoma 73022

PLEASE PROVIDE THE FOLLOWING DOCUMENTATION:

- ➔ **PROOF OF ENROLLMENT IN A FEDERALLY RECOGNIZED TRIBE**
- ➔ **DRIVER'S LICENSE OR STATE ISSUED IDENTIFICATION**
- ➔ **PROOF OF RESIDENCY (Utility Bill, Rent Receipt, Lease Agreement or Residence Verification Form)**
- ➔ **PROOF OF DISABILITY (Documentation of Disability Form)**

Cheyenne and Arapaho American Indian Vocational Rehabilitation Program (CAAIVR) has 60 days to determine your eligibility. If you have not submitted the required information within 60 days, your case will be closed as "ineligible".

If further information is needed to help make a decision regarding your disability, an extension may be granted.

APPLICATION FOR SERVICES

1. I am applying for services from the Cheyenne and Arapaho Rehabilitation Program. I understand that in order to receive Vocational Rehabilitation Services, I must have:

   a. A physical or mental capacity which interferes with finding a job, and

   b. A reasonable chance to be able to work after I receive Vocational Rehabilitation Services.

2. If I am found eligible, I understand that my counselor will involve me in planning my rehabilitation program and my plan will be reviewed at least once a year. Similar benefits and referrals to other agencies will also be used to assist me in meeting my rehabilitation program goal(s). I understand that I must keep scheduled appointments.

3. I understand that rehabilitation services are dependent upon the availability of openings at the Cheyenne and Arapaho Rehabilitation Program 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 rehabilitation program staff by requesting a meeting with the Program Director, verbally, or in writing within 30 days of the effective date of the decision to my application. I also understand that I may continue to appeal any grievance beyond the Program Director's level, provided, that I make this request 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 REVIEWED WITH ME AND I HAVE BEEN GIVEN A COPY.

_____ _____

Applicant's Signature
(Parent/Guardian, if applicable)

Date

_____ _____

Program Counselor

Date

CLIENT INFORMATION

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

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NO. _____-_____-_____

SEX: ☐ MALE ☐ FEMALE EMAIL: _____

TELEPHONE NO. (____) _____-_____ ALTERNATE NO. (____) _____-_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

ARE YOU ENROLLED WITH A FEDERALLY RECOGNIZED INDIAN TRIBE: ☐ YES ☐ NO

If so, what Tribe? _____ Roll #: _____

****

PHYSICAL ADDRESS: MAILING ADDRESS:

_____ _____

_____ _____

COUNTY: _____ COUNTY: _____

****

ARE YOU THE PARENT OR GUARDIAN OF THE APPLICANT? ☐ YES ☐ NO

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

GUARDIAN'S NAME: _____
(Last) (First) (Middle)

(If Guardian, please provide guardianship documentation)

For office use

Received by:

_____ _____ _____
Print Name Signature Date

Assigned Counselor: _____

HAVE YOU EVER APPLIED FOR REHABILITATION OR VISUAL SERVICES?

☐ YES If so, when? _____
☐ NO

WHO REFERRED YOU TO OUR PROGRAM? _____

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

_____

_____

_____

HAVE YOU EVER BEEN SEEN BY A DOCTOR FOR PROBLEMS RESULTING FROM YOUR DISABILITY? ☐ YES ☐ NO

1. _____ _____
(Doctor's Name and Address) (Doctor's Phone Number)

_____ _____
(Dates seen by Doctor) (Reason seen)

2. _____ _____
(Doctor's Name and Address) (Doctor's Phone Number)

_____ _____
(Dates seen by Doctor) (Reason seen)

3. _____ _____
(Doctor's Name and Address) (Doctor's Phone Number)

_____ _____
(Dates seen by Doctor) (Reason seen)

DO YOU HAVE MEDICAL/HOSPITAL INSURANCE THROUGH YOUR EMPLOYER?

☐ YES Company name _____
Company address _____
_____
Policy Number _____

☐ NO State reason _____
_____
_____
_____

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

☐ YES If yes, please provide:

➔ Insurance type _____

➔ Address _____

_____

➔ Policy Number _____

☐ NO List reason:_____

****

* TOTAL NUMBER RESIDING IN THE HOUSEHOLD: _____

ARE YOU EMPLOYED? ☐ YES ☐ NO

HOURS WORKED IN WEEK PRIOR TO APPLICATION: _____

EARNINGS IN WEEK PRIOR TO APPLICATION? _____

ARE YOU ON SHORT TERM/LONG TERM DISABILITY? ☐ YES ☐ NO

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

Name	Relationship	Employer	Weekly work hours	Weekly salary

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

Source	Amount	Case Number	Beginning	Ending

SSI Status: _____ SSDI Status: _____

MILITARY SERVICE

HAVE YOU SERVED IN THE ARMED FORCES OF THE UNTED STATES? ☐ YES ☐ NO

If yes, what branch of service? _____

Type of Discharge _____ Date of Discharge _____

(0=Not an Applicant, 1=Applicant Allowed Benefits, 2=Applicant Denied Benefits, 3=Status of Applicant Pending, 4=Not Known if Applicant, 5=Benefits Discontinued Prior to Application)

****

EDUCATION

Highest Grade Completed: _____ Special Education Student: ☐ YES ☐ NO

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

LIST YOUR EDUCATION HISTORY:

HIGH SCHOOL: _____
Name of College/University

_____
Address City, State, Zip

Highest Grade Completed: _____ Special Education Student: ☐ YES ☐ NO

COLLEGE: _____
Name of College/University

_____
Address City, State, Zip

Grades/Hours Completed _____ Major _____ Year(s) Attended _____

TECHNICAL: _____
Name of College/University

_____
Address City, State, Zip

Grades/Hours Completed _____ Major _____ Year(s) Attended _____

OTHER: _____
Name of School

_____
Address City, State, Zip

Grades/Hours Completed _____ Major _____ Year(s) Attended _____

EMPLOYMENT

LIST YOUR LAST THREE (3) JOBS:

1. Job Title: _____ Dates Employed: _____
   Employer Name: _____ _____
   Address: _____ Reason for leaving: _____
   Weekly Salary: _____ _____

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2. Job Title: _____ Dates Employed: _____
   Employer Name: _____ _____
   Address: _____ Reason for leaving: _____
   Weekly Salary: _____ _____

---

3. Job Title: _____ Dates Employed: _____
   Employer Name: _____ _____
   Address: _____ Reason for leaving: _____
   Weekly Salary: _____ _____

****

REFERENCES:

LIST THREE (3) PEOPLE WHO WILL ALWAYS KNOW HOW TO LOCATE YOU:

1. Name: _____ Relationship: _____
   Address: _____ Phone Number: _____

2. Name: _____ Relationship: _____
   Address: _____ Phone Number: _____

3. Name: _____ Relationship: _____
   Address: _____ Phone Number: _____

DO YOU PARTICIPATE IN NATIVE AMERICAN INDIAN CEREMONIAL ACTIVITIES?

☐ YES If so, what?

_____

_____

_____

_____

_____

☐ NO

This is confidential information and no penalty will be inflicted for right or wrong answers.

****

WHAT SERVICES DO YOU NEED?

_____

_____

_____

_____

_____

_____

_____

_____

For office use only

Has applicant met all requirements for services? ☐ YES ☐ NO

If yes; applicant is approved for services for a period of _____,
Beginning: _____, 20 _____ to _____, 20_____.

If no; please state reason: _____

_____

Additional comments: _____

_____

_____

_____

_____

Cheyenne and Arapaho Vocational Rehabilitation Program

Consumer ID #: _____ **VR Counselor: _____**

Name: _____ DOB: ___/___/_____ SS #: _____-____-_____

Dear Physician;

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 individuals' 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 the disability:

   _____

   _____

5. Recommendations for individual's Vocational Rehabilitation Plan:

   _____

   _____

Physician Name (Print): _____ Date: _____

Physician Signature: _____ Date: _____

Cheyenne and Arapaho Tribes Vocational Rehabilitation Program
Authorization to Release/Obtain Information

Consumer Name: _____ Consumer ID #: _____

Consumer Address: _____
Street City, State, Zip

The Office of the Cheyenne and Arapaho Tribes Vocational Rehabilitation Program (CATVR) has my permission to release or obtain information indicated in item #1 below. This information may include reports about my physical or mental condition, school records, facts necessary to determine my financial needs or other information that CATVR needs to determine my eligibility and to provide vocational rehabilitation services. I understand that information disclosed according to this consent may be subject to re-disclosure and will no longer be subject to the HIPPA Privacy requirements. If I no longer wish to have my information disclosed, I will notify CATVR in writing. This will not affect actions already taken with my permission. My permission to release or obtain information expires on _____, 20_____, or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released or obtained? (Please be specific) _____

_____

_____

_____

_____

- Who is releasing this information? (Insert the full name of this person or organization)

  _____

- Who is receiving this information? (Insert complete information about this person)

  Name: _____

  Title: _____

  Address: _____

- Why is this information needed? _____

  _____

I have read all of the information on this form. I understand and agree to what it states.

Consumer or Parent/Guardian Signature: _____ Date: _____

This release meets all requirements of 45 Code of Federal Regulations (CFR), Part 164.508 which implements HIPPA; 34 CFR, Part 99, which implements the Family Education Rights and Privacy Act; and 42 CFR, part 2 which governs the confidentiality of alcohol and drug abuse records.

Consumer ID #: _____ VR Counselor: _____

RESIDENCE VERIFICATION FORM

(Please print)

I, _____ verify that _____

resides at _____, _____, _____, _____

Street city state zip

in the county of _____.

I certify that I am the owner of the residence and/or the owner of the lease to the residence at:

_____, _____, _____, _____

Street city state zip

I offer the attached document as verification of this residence and, I testify that, _____ _____resides in my residence on a permanent basis. My relationship to the consumer is a relative/friend.

Type of verifiable document: _____

_____

Signature of Residence Owner: _____ Date: _____

Signature of Consumer: _____ Date: _____

Signature of Counselor: _____ Date: _____

DEPARTMENT OF LABOR

CLIENTS RIGHTS AND REMEDIES

If there are questions or concerns about the decisions made in the administration or my rehabilitation program, I may call the Cheyenne and Arapaho Vocational Rehabilitation Program Director for an informal appeal at (405) 422-7617.

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 toll free at 1-800-522-8824 or local (405) 521-3756.

I understand that I may request an informal administrative review or a formal appeal if I do not agree with the decision made by my counselor regarding the establishment or denial of vocational rehabilitation services. A formal appeal may be requested by contacting the Cheyenne and Arapaho Tribes Executive Director of the Department of Labor at (405) 262-0345, Ext. 27662. Subsequently, if not satisfied, I may appeal to the Cheyenne and Arapaho Tribes Executive Branch. If not satisfied, you may file a claim in the Cheyenne and Arapaho Tribal Court. I may have a representative at my own expense.

My signature to this document constitutes that I have been informed and made aware of my rights through the Client Assistance Program (CAP). 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 the Rehabilitation Act of 1973 as amended. Failure to provide this information may prevent the Cheyenne and Arapaho Vocational Rehabilitation Program from providing services in a timely manner. Information will not be disclosed to an individual, agency, or organization without my written consent or that of my parent, guardian, or representative as applicable.

Consumer Name: _____ Date: _____
Please print

Consumer Signature: _____

Consumer Representative: _____ Date: _____
Please print

Representative Signature: _____