APLEASE PROVIDE THE FOLLOWING DOCUMENTATION:

- **PROOF OF ENROLLMENT IN A FEDERALLY RECOGNIZED TRIBE**
- **DRIVER'S LICENSE OR STATE-ISSUED ID**
- **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.

Main Office Contact Info

Phone: 405-422-7617

Email: CAAIVR@cheyenneandarapaho-nsn.gov

Fax: 405-422-8213

Address: P.O. BOX 167 Concho, OK 73022

CHEYENNE & ARAPAHO TRIBES
Vocational Rehabilitation Program

APPLICATION FOR SERVICES

1. I am applying for services from the Cheyenne and Arapaho American Indian Vocational Rehabilitation (CAAIVR) Program. I understand that to be eligible for Vocational Rehabilitation services, I must:

   a. Have a physical or mental condition that creates a barrier to obtaining or maintaining employment; and
   b. Have a reasonable expectation of achieving an employment outcome with the support of Vocational Rehabilitation services.

2. If I am determined eligible, I understand that my Vocational Rehabilitation Counselor will work with me to develop an individualized plan for employment. This plan will be reviewed at least once each year. I also understand that comparable benefits and services from other programs or resources may be used to support my rehabilitation goals. I agree to attend and participate in scheduled appointments.

3. I understand that services are provided based on the availability of program openings and funding within the CAAIVR Program.

4. I understand that I have the right to appeal any decision made by CAAIVR staff. I may request a review by the Project Director either verbally or in writing within 30 days of the effective date of the decision. If I am not satisfied with the outcome, I may continue the appeal process beyond the Project Director level, if I submit my request within 30 days of that decision.

5. I understand that all personal information collected by the CAAIVR Program will be kept confidential and handled in accordance with applicable privacy laws and program policies.

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

COPY OF IT.

_____ _____

Applicant's Signature Date

(Parent, guardian, if applicable)

CLIENT INFORMATION

NAME: _____

(Last) (First) (Middle)

SOCIAL SECURITY NUMBER: _____

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

TELEPHONE

NUMBER: _____ _____

(Home) (Alternate)

Email:_____

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

MARITIAL STATUS: [ ] Married [ ] Single [ ] Widowed [ ] Divorced

[ ] Separated

TRIBAL AFFILIATION: _____ **ENROLLMENT NUMBER**:_____

TOTAL NUMBER OF PEOPLE IN THE HOME: _____

HOME ADDRESS: _____

(Street, Route or P.O. Box)

FINDING DIRECTIONS: _____

COUNTY: _____

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

_____

_____

_____

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

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

_____

[ ] NO List reason: _____

WHO REFERRED YOU TO OUR OFFICE? _____

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

If yes, please list:

1. _____

(Dr.'s Name and Address) (Dr.'s Telephone Number)

_____

(Dates Seen By the Doctor) (Reason Seen)

2. _____

(Dr.'s Name and Address) (Dr.'s Telephone Number)

_____

(Dates Seen By the Doctor) (Reason Seen)

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 VOCATIONAL REHABILITATION OR VISUAL SERVICES?

[ ] YES If so, when? _____[ ] NO

HAVE YOU EVER DEFAULTED ON A STUDENT LOAN? [ ] YES [ ] NO

ARE YOU A VETERAN? [ ] YES [ ] NO

If yes, specify: _____

SSI Status: _____ **SSDI Status**: _____

(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)

Highest Grade Completed: _____ **Special Education Student**: [ ] Yes [ ] No

Work Status: _____ **Hours Worked in Week Prior to Application**: _____

Earnings in Week Prior to Application: _____

LIST YOUR EDUCATION HISTORY: **HIGH SCHOOL**

_____

(NAME OF SCHOOL) (ADDRESS) (CITY/STATE)

_____

(GRADES/HOURS COMPLETED) (DATES)

COLLEGE/UNIVERSITY

_____

(NAME OF SCHOOL) (ADDRESS) (CITY/STATE)

_____

(GRADES/HOURS COMPLETED) (MAJOR) (DATES)

TECHNICAL TRAINING

_____

(NAME OF SCHOOL) (ADDRESS) (CITY/STATE)

_____

(GRADES/HOURS COMPLETED) (MAJOR/CERTIFICATION) (DATES)

LIST YOUR LAST THREE (3) JOBS:

1. _____

(JOB TITLE) (EMPLOYER NAME AND ADDRESS) (WEEKLY SALARY)

_____

(DATES EMPLOYED) (REASON FOR LEAVING)

2. _____

(JOB TITLE) (EMPLOYER NAME AND ADDRESS) (WEEKLY SALARY)

_____

(DATES EMPLOYED) (REASON FOR LEAVING)

3. _____

(JOB TITLE) (EMPLOYER NAME AND ADDRESS) (WEEKLY SALARY)

_____

(DATES EMPLOYED) (REASON FOR LEAVING)

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

1. NAME: _____ RELATIONSHIP: _____

   ADDRESS: _____ TELEPHONE: _____

2. NAME: _____ RELATIONSHIP: _____

   ADDRESS: _____ TELEPHONE: _____

3. NAME: _____ RELATIONSHIP: _____

   ADDRESS: _____ TELEPHONE: _____

DO YOU PARTICIPATE IN NATIVE AMERICAN INDIAN CEREMONIAL ACTIVITIES? IF SO, WHAT?

_____

_____

_____

WHAT SERVICES OR SUPPORTS DO YOU NEED TO REACH YOUR EMPLOYMENT GOALS?

_____

_____

_____

Medical Form

Consumer ID #_____ VR Counselor: _____

Cheyenne and Arapaho American Indian Vocational Rehabilitation program

NAME: _____ DATE OF BIRTH: _____

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 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 this disability.
_____
_____
_____

(5) Recommendations for individual's Vocational Rehabilitation plan:
_____
_____.

THANK YOU FOR YOUR ASSISTANCE

***Physician Signature:** _____ **Date:** _____

Physician Name (please print): _____ Date: _____

***A LICENSED MENTAL HEALTH PROFESSIONAL MAY ALSO FILL THIS FORM OUT FOR A PSYCHOLOGICAL AND/OR BEHAVIORAL DISABILITY.**

NOTICE OF APPEAL RIGHTS, CAP, AND CONFIDENTIALITY

APPEAL RIGHTS

- Questions or concerns about the rehabilitation program may be addressed through an informal review with the CAAIVR Program Director at (405) 422-7617.
- If the consumer disagrees with a decision about services, the consumer may request an informal review or a formal appeal through the Executive Director of Labor at (405) 262-0345, Ext. 27660.
- The consumer may have a representative assist during the appeal process at the consumer's expense.
- If the formal appeal decision is unsatisfactory, the appeal may continue under CAAIVR policy, including review by the Cheyenne and Arapaho Tribes Executive Branch.
- If still dissatisfied, the consumer may file a claim in Tribal Court.

CLIENT ASSISTANCE PROGRAM (CAP)

- The consumer has been informed of the Client Assistance Program (CAP), which may assist with questions, concerns, or appeals related to vocational rehabilitation services.
- Toll-Free: 1-800-522-8224.
- Phone: (405) 522-6702.
- Oklahoma Office of Disability Concerns, located at P.O. Box 25352 Oklahoma City, Oklahoma 73125.

CONFIDENTIALITY

- Information provided to CAAIVR will be kept confidential and used only for eligibility, services, program administration, and legal compliance.
- Information will not be released without written consent except as permitted or required by law.
- Failure to provide complete or accurate information may delay eligibility or services.

ACKNOWLEDGMENT

- By signing below, the consumer acknowledges notice of appeal rights, CAP assistance, and confidentiality protections.

Consumer Name/Consumer Representative: _____ Date: _____

☐ Copy was provided to consumer

RESIDENCE VERIFICATION STATEMENT

This statement is to verify that: _____

Resides at: _____

City: _____

County: _____

Type of verifying document attached: _____

Signature of Residence Owner: _____ Date: _____

Signature of Consumer: _____ Date: _____

Signature of Counselor: _____ Date: _____