



**ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS
VOCATIONAL REHABILITATION**

APPLICATION FOR VOCATIONAL REHABILITATION SERVICES

1. Name: _____
(First) (MI) (Last) (Maiden)

2. Age: _____ Date of Birth: _____

3. PERSONAL:

Race: () Ak. Native/American Indian () Caucasian () African American () Asian/Pacific Islander

Sex: () M () F **Marital Status:** () Married () Separated () Never Married

Are you a U.S. citizen? () No () Yes If no, explain: _____

4. Home or Message Phone: _____ (please note home or message number)

5. Mailing Address: _____
Street or P.O. Box City State Zip

6. Contact Person: _____ Address: _____ Phone: _____

7. Who Referred you to Vocational Rehabilitation? _____

8. Have you ever applied for vocational rehabilitation services before? () Yes () No

If yes, where? _____ When? _____ Counselor's Name _____

Services received: _____

I am requesting services from the AVCP Vocational Rehabilitation for the following disability:

I am requesting the following types of services from the AVCP Vocational Rehabilitation:

What will you accomplish as a result of receiving services? _____

By signing this application, I am requesting services from the AVCP Vocational Rehabilitation. I further certify that the information provided herein is correct.

Signature of Applicant

Signature of Representative (if applicable)

Date

Date

THIS SECTION TO BE COMPLETED BY THE COUNSELOR AT INTAKE

SUPPLEMENTAL APPLICATION INFORMATION

1. HOUSEHOLD INFORMATION:

Number living in the house? _____ How many dependants? _____

<u>Name</u>	<u>Relationship/Age</u>	<u>Name</u>	<u>Relationship/Age</u>

Are any of the above in another residence? () No () Yes If yes, type? _____

2. HEALTH INFORMATION:

Are you covered under Indian Health Services (IHS)? () No () Yes

Do you have health insurance? () No () Yes

If you are working, is health insurance available through your job? () No () Yes

Personal Doctor and other doctors/hospitals who are familiar with applicants condition:

<u>Name</u>	<u>Address</u>	<u>Last Seen</u>
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____

Date when disability began? _____

Is disability a result of a work related injury? () No () Yes

If yes, date of the accident? _____ Employer _____

Currently taking medication? () No () Yes If yes, what type? _____

Currently under treatment? () No () Yes If yes, what type? _____

Do you use substances such as alcohol or drugs? () No () Yes

Can applicant travel without assistance/escort? () No () Yes explain: _____

Receiving personal care attendant services? () No () Yes If yes, Hrs/day _____

3. EDUCATION:

Highest grade completed: _____ Date of Graduation: _____

GED? () No () Yes If yes, date received _____

Were you in Special Education? () No () Yes Name of school _____

List any other schools attended:

<u>School</u>	<u>Degree/Certificate</u>	<u>Dates Attended</u>

4. EMPLOYMENT INFORMATION – Employment status

___ Self Employed ___ Working ___ Not working ___ Student ___ Other

Please explain other: _____

Employment history (recent job first)

Employer _____ From _____ To _____
Address _____ Reason for leaving _____
Job Duties _____
Hourly Wage \$ _____

Employer _____ From _____ To _____
Address _____ Reason for leaving _____
Job Duties _____
Hourly Wage \$ _____

Employer _____ From _____ To _____
Address _____ Reason for leaving _____
Job Duties _____
Hourly Wage \$ _____

Employer _____ From _____ To _____
Address _____ Reason for leaving _____
Job Duties _____
Hourly Wage \$ _____

May we notify your recent employer? () No () Yes If no, please explain: _____

5. LEGAL:

Do you have a valid Alaska's Drivers License? No Yes If yes, number _____
Do you have your own transportation? No Yes
Have you ever been convicted for a DWI/DUI? No Yes
Have you ever been arrested or convicted? No Yes
If yes, explain: _____ What year(s) _____

If yes to either of the above, are you currently on probation or parole? No Yes

6. VETERAN:

Are you a Veteran? No Yes
If yes to the above, note branch of service, type of discharge, and period served: _____

7. FINANCIAL:

Do you or any of the residents receive any assistance from the following sources?

(Source)	(Type)	(Monthly Amount)	(How Long)
Public Assistance	_____	_____	_____
TANF	_____	_____	_____
ASHA Housing	_____	_____	_____
Worker's Comp.	_____	_____	_____
Social Security	_____	_____	_____
Annuity/Private Insurance	_____	_____	_____
Veteran's Benefits	_____	_____	_____
Food Stamps	_____	_____	_____

What is your primary source of support? _____

***If at anytime you start receiving additional resources (i.e. unemployment, energy assistance, TANF, settlements, etc.), you need to contact our office with that information right away for our records.**

CERTIFICATION

The consumer has been provided the following information:

- 1. A general overview of the VR process _____
- 2. How one gets in to the VR system _____
- 3. The responsibility of the consumer _____
- 4. The services which are offered by VR _____
- 5. The rights of an applicant/consumer of VR _____
 - a) Client Assistance Program (CAP)_____
 - b) How to appeal a decision of action of VR_____
 - c) Confidentiality of information _____
- 6. Other VR services (DVR)_____

(VR = Vocational Rehabilitation)

Counselor Signature

Date

The above topics have been explained to me at the time of orientation/intake to Vocational Rehabilitation. I understand the rights and responsibilities I have as an applicant/consumer of the AVCP Vocational Rehabilitation and am willing to abide by them.

Applicant/Representative Signature

Date

AVCP VOCATIONAL REHABILITATION

Authorization To Release Information

For the purpose of documenting a disabling condition, for use in the determination of eligibility for services through the Association of Village Council Presidents Vocational Rehabilitation Program, and for exchange of information for service plan development and ongoing services. I _____, applicant (please print)

DOB _____ request the release of information to be exchanged as required between AVCP Vocational Rehabilitation Program and:

Yes / No (please initial)

- ____/____ 1. YKHC and/or Indian Health Services Medical Records
- ____/____ 2. YKHC Behavioral Health
- ____/____ 3. _____ School District Special Education
- ____/____ 4. Dr. Lorin Bradbury
- ____/____ 5. Psychologist, Sarah Angstman
- ____/____ 6. Alaska Psychiatric Institute (API)
- ____/____ 7. YKHC Phillips Alcohol Treatment Center (PATC)
- ____/____ 8. Bethel Therapeutic Court
- ____/____ 9. State Division of Vocational Rehabilitation Program
- ____/____ 10. Bethel Community Services Developmental Disabilities Program
- ____/____ 11. State Division of Public Assistant Program
- ____/____ 12. Other agencies involved _____

Signature of Applicant

Date

Representative (if applicable)

Date

* This document will expire 12 months from the date of signature