



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 **Martial Status:** () Married () Separated () Never Married

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: _____ 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 goal will you accomplish as a result of receiving services? **EMPLOYMENT or
SUBSISTENCE**? _____

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

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>

2. HEALTH INFORMATION:

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

Do you have health insurance (Medicaid or Medicare)? () No () Yes

Do you have private health insurance? () 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. _____	_____	_____

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? _____

Are you seeing or have been seen by Behavioral Health? () No () Yes

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 _____ Certificate of Completion? () No () Yes

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 (Native Crafts, etc.) ____ Working ____ Not working ____ Student

____ Small Business ____ 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 \$ _____

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 (SSI or SSDI)	_____	_____	_____
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 | _____ | 5. The rights of an applicant/consumer of VR | _____ |
| 2. How one gets in to the VR system | _____ | a) The Client Assistance Program (CAP) | |
| 3. The responsibility of the consumer | _____ | b) How to appeal a decision of action of VR | |
| 4. The services which are offered by 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

