The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
P.O. Box 129/122 W Broadway, Anadarko, OK 73005
Phone: (405) 247-2425 ext. 182
www.vocrehab@wichitatribe.com

Dear Applicant:

Thank you for your interest in the Wichita and Affiliated Tribes Vocational Rehabilitation Program (WATVR). WATVR is designed to help individuals with physical, cognitive and/or mental disabilities become employed or continue employment within a job that is compatible with their condition. All services provided by the WATVR will be implemented with the overarching goal of securing gainful employment for our clients. If you meet eligibility requirements, you will be connected to our Vocational Rehabilitation (VR) Counselor to start developing an Individualized Plan for Employment (IPE). The IPE will consist of outlining your individual needs and seek ways to address your specific needs in an effort to help you become employed.

To determine your eligibility for services, please complete the enclosed application as thoroughly as possible. If you have any questions about the application process, please contact our office at the contact information listed above or ask the VR Counselor at your scheduled appointment. The more information you include on this application, the quicker we are able to determine your eligibility for services.

Please be sure to include all the items listed on the ***Documentation Checklist*** when submitting your application. If you are determined eligible for the WATVR Program we will work with other Tribes and the Oklahoma Department of Rehabilitation Services (DRS), to help you reach your employment goal. If you are already receiving services from either entity, please let us know so we can be sure to maximize your services.

So:ti:c?a for your interest in our program. We look forward to serving you!

-WATVR Staff

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
Documentation Checklist

Applicant must provide at least one form of documentation for each of the following areas below. If further explanation is needed, please contact WATVR @: (405) 247-2425 ext. 182 or email: www. vocrehab@wichitatribe.com

- I have thoroughly completed the application (Pages: 1-8).
- **PROOF OF INCOME** (Include All Income for All Household Members)
  - Social Security Award Letter and/or VA Disability Award Letter
  - Copy of benefits check(s)
  - Income Verification from the Department of Human Services (DHS) or letter stating current services.
    - Employment Wages (Document must include one month of wages accrued)
      - Letter from employer- Must be on letterhead stationery or notarized and include: Dates of employment and Average hours worked per week ***OR***
      - Copy of most recent check stubs
- **PROOF OF TRIBAL ENROLLMENT**
  - Verification of tribal enrollment (Letter or card from Tribe's Enrollment Office)
  - Any Federally Recognized Tribe
- **PROOF OF AGE**
  - CDIB/Tribal Enrollment Card
  - Driver's License or State-Issued ID
  - Military-Issued ID
- **PROOF OF SOCIAL SECURITY NUMBER**
  - Social Security Card
  - Documentation from the Social Security Administration stating your SSN
  - Tribal Enrollment Verification with your SSN included
  - Military-Issued ID with your SSN included
- **PROOF OF CURRENT LIVING ADDRESS------Must reside within service area *(see below)***
  - Utility Bill (In your name)- Gas, electric or water bill--*No bill such as phone, internet, cable, etc.*
  - Rent Receipt or Lease (In your name)
  - Voter's Registration Card
  - Completed WTVR Residence Form- Along with one of the above documents for the person who leases, owns, or rents residence.
- **PROOF OF DISABILITY ***** *Include details indicating you CAN work with assistance from VR, if able.***
  - Doctor/Medical Professional's Statement (Verifying disability/limitations within past year)
  - School Assessment Records (IEP, etc.)
  - Copy of Disability Check/Payment from one of the following: Social Security Disability Insurance (SSDI), Aid to Disabled, VA Disability, or SSI
  - Completed WTVR Documentation of Disability form from an approved medical professional

Service Area Includes the Counties of: Blaine, Caddo, Canadian, Grady, Washita, & Kiowa

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
Applicant Information

Application #: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ___/____/_____ Contact# :(___) ____-_____ Email: _____

Marital Status: __Single __Married __Divorced __Separated Gender:_____

Social Security Number: _____-_____-_____ Total # of People in Home: ____ Tribal Affiliation: _____

Mailing Address: _____ Town/City: _____ State: ____ Zip Code: _____

Guardian or Emergency Contact Name: _____ Contact#: (_____) _____-_____

Veteran (*Circle one*): Y N Service Connected? (*Circle one*): Y N If yes, specify: _____

**If you are a Veteran, please provide copy of DD214/Military Verification and VA Benefit Summary Letter*

SSI/SSDI *(Circle one):* Y N SSI Status: _____ SSDI Status: _____

[O = Not an Applicant, I = Applicant Allowed Benefits, 2 = Applicant Denied Benefits,3 = Status of Application Pending, 4 = Not Known If Applicant, 5 = Benefits Discontinued Prior to Application]

What is your disability? _____

_____

_____

How does it limit your ability to work? _____

_____

_____

Have you been seen by a doctor for problems resulting from your disability? Y N

_____ _____ _____

Doctor's Name Address Phone

_____ _____

Date Seen Reason Seen

Do you have Private/Medical/Hospital Insurance/Medicare/Medicaid? Y N *If yes, please provide documentation.*

How were you referred to our office? _____

Have you ever applied for rehabilitative services or visual services? Y N If yes, when? _____

Do you participate in any Native American ceremonies, dances, activities, etc.? If so, please explain.

_____

_____

_____

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
Applicant Information
Education/Employment/Salary Information

Highest Grade Completed (*Circle one*): HS Vocational Training AA/AS BA/BS MA/MS PHD/MD/JD
Special Education Student? (*Circle one*): Y N Have you ever defaulted on a student loan (*Circle one*): Y N
If yes, are you currently in good standing? (*Circle one*): Y N

Name of High School:_____Year Graduated:_____Degree Received:_____

Name of College/University:_____Year Graduated:____Degree Received: ____

Name of College/University:_____Year Graduated:____Degree Received: _____

Technical Training Institution: _____

Course Title:_____ Length of Course: _____

List your three most recent periods of employment:
1) Job Title:_____Employer Name:_____

Employer Address:_____ Period of Employment:_____to _____

Reason for leaving: _____

Job Duties:_____Hours Worked: _____

2) Job Title:_____Employer Name:_____

Employer Address:_____ Period of Employment:_____to _____

Reason for leaving: _____

Job Duties:_____Hours Worked: _____

3) Job Title:_____Employer Name:_____

Employer Address:_____ Period of Employment:_____to _____

Reason for leaving: _____

Job Duties:_____Hours Worked: _____

Current Work Status (*Circle one*): Employed Unemployed Weekly Earnings: $_____ Hrs. Worked: ____

Do you have income from any source? (*Circle one*): Y N
If yes, please list your source information: *(SSI, SSDI, Social Security, Public Assistance, Worker's Comp. etc.)*

Source	Amount	Case Number	Date Received

List Members of your Immediate Household with Employment and Income Information:

Name	Relationship	Employer	Weekly Hrs. Worked	Weekly Net Salary

Contact Information

Please list 3 people who you associate with and who may be contacted to reach you.

1. Name: _____
   Relationship: _____ Email: _____
   Address: _____
   Phone: _____
2. Name: _____
   Relationship: _____ Email: _____
   Address: _____
   Phone: _____
3. Name: _____
   Relationship: _____ Email: _____
   Address: _____
   Phone: _____

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
Applicant Information
Explanation of Services

EXPLANATION OF SERVICES

A paragraph typed or handwritten by the client explaining, **what services would you like to receive**, **why you need services** and **what it will be used for**.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any misdemeanors? Yes No Do you have any felonies? Yes No Please explain if yes

_____

_____

_____

The Client Assistance Program has been reviewed with me and I was given a copy of the CAP brochure.

Applicant's Signature: _____ Date: _____

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program

Application for Services

I am applying for services from the Wichita and Affiliated Tribes Vocational Rehabilitation Program (WATVR).

1. I understand that in order to receive Vocational Rehabilitation (VR) services, I must have:
    a. A medically diagnosed physical or mental disability which interferes with me obtaining a job, and
    b. A likely chance that I will be able to work after I receive VR services.
2. I understand that by applying for VR services, I am entitled to an evaluation of my eligibility.
3. If I am found eligible, I understand that my counselor will involve me in the development of my Individualized Plan for Employment (IPE) and my IPE 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 IPE.
4. I understand that I must keep scheduled appointments.
5. I understand that VR services are dependent upon the availability of funds and openings at the WATVR and the state agency for rehabilitation assistance.
6. I am aware that I have the right to appeal decisions made by the WATVR staff by requesting a meeting with the VR Director either verbally or in writing within 3 days of the decision's effective date. I also understand that I may continue to appeal any grievance beyond the Director's level provided that I make this request within 30 days of the Director's decision.
7. I understand that all information provided by me will be treated in a confidential manner.

Client Responsibilities

To make the rehabilitation effort a success, the client and VR Counselor must work together to reach the client's identified goals. This shared responsibility requires that the client accept the following responsibilities:

1. Refrain from threats (physical or verbal): WATVR 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 VR Counselor informed of changes in the client's address, financial status or other program related changes.
9. Apply for and use any comparable benefits and services for which the client is eligible to defray in whole or in part the cost of services in the IPE.
10. Actively engage with the VR Counselor to obtain suitable gainful employment.

I have read the above statements. I hereby confirm and agree to adhere to the requested information and understand my rights to appeal my eligibility decision if needed. I also agree that all the information is true to the best of my knowledge and any misrepresentation of information given in this application could be construed as fraudulent and may affect my assistance. I have also received a copy for my records.

Applicant's Name	**Applicant's Signature**	**Date**

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program

Authorization for Release of Information

I. I, _____, hereby request the disclosure of information from my record.
(Name of Patient)

II. **The information is to be disclosed by:** **And is to be provided to:**

	NAME OF FACILITY	NAME OF FACILITY **WATVR**
	ADDRESS	ADDRESS **122 W. Broadway**
	CITY/STATE/ZIP CODE	CITY/STATE/ZIP CODE **Anadarko, OK 73005**

III. **The purpose or need for this disclosure is:**

_____ _____

IV. **The information to be disclosed from my health record:** (*check appropriate box(es)*)

- ☐ Entire Record
- ☐ Only Information related to *(specify)* _____
  _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify)* _____
- ☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Vocational Rehabilitation Program, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event.*

_____
(Enter if date is different from **one year after** date below)

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Client/Authorized Representative: _____ Date: _____

VR Counselor: _____ Date: _____

DOB:_____ SSN:_____

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
Documentation of Disability

Name: _____ Date of Birth: _____ SSN: _____

Address: _____

Dear Doctor/Medical Professional:

The above individual has applied for rehabilitation services. In order to assist the applicant, I am required by Federal Law to verify that this individual has a significant disability which results as an impairment 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) Recommendations for Treatment:

_____

_____

_____

_____

4) Can this individual's condition be improved through treatment? *(Circle one):* Y N Unknown

If yes, what type(s) of treatment are recommended? _____

_____

_____

5) Functional Limitation(s): *Please list all perceived limitations and restrictions created by this disability*.

_____

_____

_____

_____

6) Recommendations for individual's vocational rehabilitation plan:

_____

_____

_____

_____

_____	_____	_____
Doctor/Medical Professional Name	Doctor/Medical Professional's Signature	Date

_____	_____
VR Counselor	Date

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
General Health Checklist

Name: _____ Last 4 of SSN:_____

Date: _____ Height: _____ Weight: _____CSLR: _____

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, cognitive 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?	☐	☐	☐	☐

The Wichita and Affiliated Tribes
Vocational Rehabilitation Program
General Health Checklist *(continued)*

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
    a. If no, why not?
    b. If yes:

Condition	Who treated you?	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Have you over been hospitalized for any of these conditions? ☐ YES ☐ NO
    a. If no, why not?
    b. If yes:

Condition	Where?	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. Are you taking any medications? ☐ YES ☐ NO
    a. If no, why not?
    b. If yes:

Condition	What medications?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____

21. Do you have restrictions from these conditions? ☐ YES ☐ NO
    a. If no, why not?
    b. If yes:

Condition	What restrictions?
_____	_____
_____	_____
_____	_____

I hereby confirm the information on this form is true to the best of my knowledge and I have not withheld any information.

_____	_____	_____
Applicant or Legal Representative's Name	Applicant or Legal Representative's Signature	Date

Additional Comments:

_____

_____

_____