Iowa Tribe of Oklahoma
Vocational Rehabilitation & Transition Application

At least one form of documentation from each category is required. Application will not be considered complete until all documentation is received.

REQUIRED DOCUMENTS CHECKLIST:

1. PROOF OF IDENTIFICATION
    a. Driver's License
    b. State Issued I.D.
2. PROOF OF INCOME (include for all family members)
    a. Social Security or VA Award Letter
    b. Copy of Benefit Check(s)
    c. DHS SNAP or TANF Printout
    d. Copy of Check Stubs (Must include dates of employment and total gross wage for the month)
    e. Letter from Employer (Must be on employer letterhead or notarized)
    f. Notarized Statement of Support
    g. Gas/Oil/Land Lease Documents
    h. Unemployment Benefit Letter
    i. Child Support Income
    j. Alimony Papers
3. PROOF OF INDIAN DESCENT
    a. Tribal membership card from any Federally Recognized Tribe
    b. Letter of Descent from Tribal Organization
4. SOCIAL SECURITY CARD
5. PROOF OF MAILING/RESIDENTIAL VERIFICATION (must match address on application)
    a. Utility Bill
    b. Rent Receipt
    c. Copy of Lease
    d. Notarized Statement of Residency
6. PROOF OF DISABILITY
    a. Doctor's statement and/or School Assessment Records
    b. Discharge papers (if recently incarcerated)
    c. Medical Records w/ Diagnosis or Disability
7. COPIES IF APPLICABLE
    a. High School transcript OR General Education Development (GED) certificate (if applicable)
    b. Student Aid Report from the Free Application for Federal Student Aid (FAFSA) for the current year
    c. Financial Need Analysis (FNA) form completed and signed by institutions' financial aid office
    d. Any Tribal Higher Education Award/Denial Letters

Please submit completed applications to:

Iowa Tribe of Oklahoma Vocational Rehabilitation (ITOVR) & Transition Services

Physical Address: 335588 E. 750 Rd.
Mailing Address: P.O. Box 728
Perkins, OK 74059
Toll-free: 1(888)336-IOWA(4692) Phone: (405)547-5721 Fax: (405)547-1090
Shawnee Office: (405)878-3854

Please complete application in blue/black ink. All information requested is necessary to determine eligibility.
Please indicate with an 'X' below which program you are applying for.

Adult Services (College/Vo-Tech)	Transition Services (H.S. Junior/Senior)

Applicant Information

Date of Application:		
Name:	E-mail Address:	
Date of birth:	SSN:	Phone:
Physical/Mailing address:		
City:	State:	ZIP Code:
Tribal Affiliation:	County of Residence:	Sex:
Marital Status:	Total Number of Family Members Living in the Home:	
Are you a Veteran? Yes No (Please circle)	Service Connected Disability? Yes No	
If yes, please list serial and dates of services:		
Are you a registered voter? Yes No (Please circle)		

Employment Information (Last Three Jobs)

Employer:		Rate of Pay:
Employer address:		Dates Employed To/From:
Phone:		Job Title:
City:	State:	ZIP Code:
Reason for Leaving:		
Employer:		Rate of Pay:
Employer address:		Dates Employed To/From:
Phone:		Job Title:
City:	State:	ZIP Code:
Reason for Leaving:		
Employer:		Rate of Pay:
Employer address:		Dates Employed To/From:
Phone:		Job Title:
City:	State:	ZIP Code:
Reason for Leaving:		

Medical/Insurance Information

Do you have Medical/Hospital Insurance including Medicare & Medicaid? Yes No (Please Circle)			
If yes, please fill in the information below:			
Name:		Address:	
City:	State:	ZIP Code:	Policy/group Number:

List Three People Who Will Always Know How to Locate You

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

Educational History

High School:		
City:	State:	Grade/Hrs. Completed:
Major:	Dates To/From:	
College:		
City:	State:	Grade/Hrs. Completed:
Major:	Dates To/From:	
Technical:		
City:	State:	Grade/Hrs. Completed:
Major:	Dates To/From	
Other:		
City:	State:	Grade/Hrs. Completed:
Major:	Date To/From:	

Are you willing to move if employment is in another city? (Answer required)

_____

_____

What is your disability and dates it occurred? (Answer required)

_____

_____

How does your disability keep you from working? (Answer required)

_____

_____

_____

How can the Iowa Tribe Vocational Rehabilitation Program assist you?

_____

_____

What are your interests and hobbies?

_____

_____

APPENDIX A. REHABILITATION SERVICES APPLICATION

My signature to this document constitutes an application for the ITOVR services. To affect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. 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 my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended by Rehabilitation Amendments of 1992, Title 56.

Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Information will not be disclosed to any individual agency or organization without my written consent or that of my parent, guardian, or representative as applicable.

APPENDIX B. STATEMENT OF INCOME AND LIABILITIES

1. Are you or a household member working full-time or part-time and earning money? [ ] Yes [ ] No
   - If yes, complete the following information:

Employed Person	Employment	Monthly Take Home Pay

2. Do you have transportation, if necessary for training or employment? [ ] Yes [ ] No

APPENDIX C. STATEMENT OF LEGAL HISTORY

1. Have you ever been convicted for a crime? (Exclude convictions that have been sealed, expunged, or legally eradicated, and misdemeanor convictions for which probation was completed and the case dismissed). [ ] Yes [ ] No

   a. If yes, please briefly describe the nature of the crime(s), the date and place of conviction and the legal disposition of the case. This program will NOT deny services to any consumer because the person has been convicted of a crime. The program however, may consider the nature, date, and circumstances of the offense as well as whether the offense is relevant to the duties and goals of the IPE you will develop with your counselor.

   _____

   _____

2. Are you currently out on bail, the subject of a current warrant for arrest, or released on your own recognizance pending trial? [ ] Yes [ ] No

   a. If yes, please briefly describe your current situation below:

   _____

   _____

I certify that this information I have given is true, correct, and complete to the best of my knowledge. I agree to notify my Rehabilitation Program Counselor within 20 days if I have changes in my living arrangement, address, income, bank accounts, automobiles, property of any kind, and expenses or needs.

I understand that the information I have given will be carefully studied and that I might be asked to provide proof of the answers given. I further understand that any false statement makes me subject to prosecution for fraud. I hereby authorize the Iowa Tribe of Oklahoma Vocational Rehabilitation Program (ITOVR) to make any necessary investigation to verify the information I have given.

When this form is returned, the ITOVR will review the information and discuss the services that can be provided and determine the amount of financial participation.

_____ _____

Consumer/Representative Signature Date

_____ _____

VR Counselor Signature Date

APPENDIX D. AUTHORIZATION FOR RELEASE OF INFORMATION

Consumer:

_____

_____

_____

Return to:

Iowa Tribe of Oklahoma Vocational Rehabilitation

P.O. Box 728

Perkins, OK 74059

Please put an 'X' on the appropriate authorization and complete the blank with the individual, school, hospital, clinic, or agency.

I hereby authorize_____to release to the Iowa Tribe of Oklahoma Vocational Rehabilitation (ITOVR) Program the following information that you have _____ pertaining to the consumer listed above.

I hereby request and authorize the Iowa Tribe of Oklahoma Vocational Rehabilitation (ITOVR) Program to release to_____the following types of _____ information which pertains to the consumer listedabove.

Please mark appropriate box and initial

THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN THEREON.

INFO	DATE OF AUTHORIZATION	INITIALS	INFO	DATE OF AUTHORIZATION	INITIALS
School Transcripts			Individualized Plan of Employment		
Other Academic Information			Employment Records		
Psychological Testing/ Psychiatric Evaluations			Financial Information		
Behavioral Health Records/ Reports			Oklahoma Department of Rehabilitation Services		
Medical Records/ Reports			Substance Abuse Treatment Program		
Hospital Records			Other (specify):		

(Optional):

THIS RELEASE OF INFORMATION WILL EXPIRE WITHOUT EXPRESS REVOCATION ON_____.
(Specify Date)

_____ _____
Signature of Consumer or Representative Date

_____ _____
Signature of Witness Date

(Must have signature of witness for consent to be valid and acceptable.)

IOWA TRIBE VOCATIONAL REHABILITATION PROGRAM GENERAL HEALTH CHECKLIST

Full Name_____Case #_____

Counselor_____DOB _____Height_____Weight _____

Please circle YES or NO if you have any of the following symptoms or conditions:	Has it kept you from working? (Please check the box accordingly) Yes	No
1. A disorder of eyes, ears, nose, or throat? YES or NO		
2. Frequent dizziness, fainting, headaches, seizures, convulsions, paralysis, or stroke? YES or NO		
3. A mental or nervous disorder? YES or NO		
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of the lungs? YES or NO		
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorders of the heart or blood vessels? YES or NO		
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gall bladder? YES or NO		
7. Disorder of kidneys, bladder, prostate, or reproductive system? YES or NO		
8. Diabetes, thyroid, or other endocrine disorders? YES or NO		
9. Arthritis, or other disorder of the muscles or bones, including spine, back or joints? YES or NO		
10. Absence of amputation of any body part? YES or NO		
11. Loss of use of arms or legs, or other body parts? YES or NO		
12. A tumor, cancer, or disorder of the lymph glands? YES or NO		
13. Allergies? YES or NO		
14. Anemia or other disorder of the blood? YES or NO		
15. Excessive use of alcohol or any habit-forming drugs? YES or NO		
16. Any other physical or mental condition? YES or NO		

If you answered YES to Question 16, please specify: _____

_____

_____

IOWA TRIBE VOCATIONAL REHABILITATION PROGRAM GENERAL HEALTH CHECKLIST (cont.)

Name and address of your personal physician/clinic: (If none, please state so):

_____

_____

_____

PLEASE ANSWER THESE QUESTIONS FOR ANY CONDITIONS MARKED "YES" ON THE PREVIOUS PAGE.

Have you been or are being treated for any of these conditions? [ ] Yes [ ] No

If yes, which conditions? _____

_____

_____

Have you been hospitalized for any of these conditions? [ ] Yes [ ] No

If yes, under what conditions? _____

_____

_____

Are you taking any medications? [ ] Yes [ ] No

If yes, list medications: _____

_____

_____

Do you have any restrictions from these conditions? [ ] Yes [ ] No

If yes, what restrictions: _____

_____

_____

To the best of my knowledge, what I have said is true and I have not withheld any information.

_____ _____

(Date) (Signature of Consumer)

Person who provided information, if not applicant: _____

Certification of Eligibility for Federal Assistance in Certain Programs

I, understand that 34 CFR 75.60, 75.61, and 75.62 require that I make specific certification of eligibility to the U.S. Department of Education as a condition of applying for Federal funds in certain programs and that these requirements are in addition to any other eligibility requirements that the U.S. Department of Education imposes under program regulations.

Under 34 CFR 75.60-75.62:

I certify that:

A. I do not owe a debt, or I am current in repaying a debt, or I am not in default (as that item used at 34 CFR Part 668) on a debt.

1. To the Federal Government under a no procurement transaction (e.g., a previous loan, scholarship, grant, or cooperative agreement):

2. For a fellowship scholarship, stipend, discretionary grant, or loan in any program of the U.S. Department of Education that is subject to 34 CFR 57.50, 75.61, and 75.62, including:

- Federal Pell Grant Program (20 U.S. 107a, et seq)
- Federal Supplemental Educational Opportunity Grant (SEOG) Program (20 U.S. 1070 (b), et seq)
- State Stafford incentive Grant Program (SSIG) 20 U.S. 1070c, et seq
- Federal Perkins Loan Program (20 U.S.C. 1087aa, et seq)
- Income Contingent Direct Loan Demonstration Project (20 U.S.C. 1087a, note):
  - Federal Stafford Loan Program, Federal Supplemental Loans for students [SLS], Federal PLUS, or Federal Consolidation Loan Program (20 U.S. 2601, et seq)
- Cuban Student Loan Program (20 U.S.C. 2601, et seq)
- Robert C. Byrd Honors Scholarship Programs (20 U.S.C. 1070d-31, et seq)
- Jacob K. Javits Fellowship Program (20 U.S.C.1134h-1134)
- Patricia Roberts Harris Fellowship Program (20 U.S.C. 1134h-1134)
- Christa McAuliffe Fellowships Program (20 U.S.C. 1105-1105j)
- Bilingual Education Fellowship Program (20 U.S.C. 3321-3262)
- Rehabilitation Long Term Training Program (29 U.S.C. 774(b))
- Paul Douglas Teacher Scholarship Program (20 U.S.C. 1104, et seq)
- Law Enforcement Education Program (42 U.S.C. 3775)
- Indian Fellowship Program (29 U.S.C. 774 (b))

B. I have made arrangements satisfactory to the U.S. Department of Education to repay a debt as describes in A.1 or A.2 (above) on which I had not been current in repaying or know which I was in default (as that term is used in 34 CFR Part 668).

C. I certify also that I have not been declared by a judge, as a condition of sentencing under section 5301 of the Anti-Drug Abuse Act of 1988 (21 U.S.C. 862), ineligible to receive Federal assistance for the period of this requested funding.

I understand that providing a false certification to any of the statements above makes me liable for repayment to the U.S. Department of Education for fund received on the basis of this certification, for civil penalties, and for criminal prosecution under 18 U.S.C. 1001.

_____ _____

(Consumer Signature) (Date)

_____

(Typed or Printed Name)

Iowa Tribe of Oklahoma
Vocational Rehabilitation Program
335588 E. 750th Road
Perkins, OK 74059
405-547-2402

CERTIFICATION OF INTENT TO PURSUE EMPLOYMENT

I am applying for services with the Iowa Tribe Vocational Rehabilitation Program. I understand I must have a documented physical or mental disability that causes an impediment to attaining and/or maintaining gainful employment.

I understand that in order to be eligible for this program and receive services, I must intend to work progressively toward attaining/maintaining suitable employment. I understand that all services provided by this program are for the sole purpose of retaining/obtaining EMPLOYMENT.

I certify that it is my full intent to work with my Rehabilitation Counselor to establish an Individualized Plan of Employment that will outline the goals and objective I need to meet to retain/obtain suitable EMPLOYMENT.

I understand that AFTER I retain/obtain employment, I will be expected to provide my Rehabilitation Counselor with information regarding the wages I am earning, name, and address of employer, and the date of employment. I understand that this information will be used to for statistical/reporting purposes only. I understand that my personal information will NOT be revealed without my written permission.

_____ _____
Consumer Signature Date

_____ _____
VR Counselor Signature Date

IOWA TRIBE OF OKLAHOMA VOCATIONAL REHABILITATION PROGRAM

CONSUMER RIGHT AND REMEDIES

I have been advised of the availability of the Consumer Assistance Program (CAP) and have received a brochure explaining the purpose of CAP and the procedures for using CAP. I or my representative may call the CAP office for assistance at 1-800-522-8224.

I understand that I may request an informal administrative review or a formal appeal if I do not agree with a decision made by my counselor regarding furnishing or denial of Vocational Rehabilitation Services. A formal appeal may be requested by contacting the Director of the Iowa Tribe of Oklahoma Vocational Rehabilitation Program: P.O. Box 728, Perkins, OK 74059; or (405) 547-2402 ext. 248.

CONSUMER RESPONSIBILITIES

To make the rehabilitation effort a success, the consumer and the ITOVR staff must work together to reach chosen goals. This shared responsibility requires that the consumer or applicant for services accept the basic responsibilities listed below. It is the counselors' responsibility to fully and appropriately inform the consumer of consumer responsibilities.

1. Keep appointments for medical examinations and evaluations.
2. Follow the advice of doctors and other licensed treatment professionals.
3. Take an active part in developing the Individualized Plan for Employment (IPE).
4. Provide enrollment documents, FAFSA submission conformation letter, Tribal award letter and letters of all scholarships received.
5. Attend training classes on a regular basis.
6. Take part in regular reviews (at least once a year) of the Individualized Plan for Employment (IPE); also take part all in amendments to the program.
7. Maintain satisfactory progress toward completing the IPE.
8. Must abstain from abuse of drugs and/or alcohol. Individuals who abuse drugs and/or alcohol while receiving services will be referred to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and/or appropriate agencies for purposes of seeking treatment. All case services will be suspended. If the consumer refuse or fails to cooperate with seeking treatment, or is not available to pursue a DRS program, this will be considered as reasonable cause for case closure.
9. Inform ITOVR staff of any change in address, financial status and any other program related changes.
10. Apply for and make appropriate use of any comparable benefits and services for which the consumer is eligible to defray in whole or in part the cost of services in the consumer's IPE and provide verifications of financial aid award status to counselor.
11. Working with the counselor to obtain suitable gainful employment or appropriate independent living outcomes as services are being completed.
12. Consumer must submit resume upon request of VR counselor.

I, the consumer, agree to practice the above responsibilities for acceptance of receiving services from the Iowa Tribe of Oklahoma Vocational Rehabilitation Program.

_____ _____

Consumer Signature Date

_____ _____

VR Counselor Signature Date

[ ] copy given to consumer