

**CHEROKEE NATION  
Career Services  
VOCATIONAL REHABILITATION**

**DOCUMENT LIST**

Applicant must provide **at least one** form of documentation **for each** of the following areas indicated. The lettered items are some examples.

**DOCUMENTS REQUIRED:**

1. \_\_\_\_\_ PROOF OF INCOME (Include income for all household members)
  - A. Social Security Award Letter or VA Award Letter
  - B. Copy of Benefit Check (s)
  - C. Income Verification from the Department of Human Services (Welfare)
  - D. Wages
    1. Letter from Employer
      - a. Must be on letterhead or notarized
      - b. Must include dates of employment and gross wages for the month
    2. Copy of check stub
2. \_\_\_\_\_ PROOF OF TRIBAL MEMBERSHIP
  - A. Tribal Membership Card
  - B. Letter from Agency (BIA)
3. \_\_\_\_\_ PROOF OF SOCIAL SECURITY NUMBER
  - A. Social Security Card
4. \_\_\_\_\_ PROOF OF PHYSICAL ADDRESS (**P.O. BOX NOT ACCEPTED**)
  - A. Utility Bill
  - B. Driver's License
  - C. Rent Receipt
5. \_\_\_\_\_ PROOF OF DISABILITY
  - A. Medical/Psychological records (last 3 years)
  - B. School Assessment Records (IEP)



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**CONSUMER INFORMATION FORM**

Please answer the following questions as accurately as you can. This information will be treated as privileged and confidential.

SOCIAL SECURITY #: \_\_\_\_\_ TICKET TO WORK?  YES  NO

MARITAL STATUS:  Married  Single  Widow(er)  Divorced  Separated

WHEN DID YOUR DISABILITY OCCUR? MONTH/YEAR: \_\_\_\_\_

HAVE YOU EVER APPLIED/RECEIVED VOCATIONAL REHABILITATION SERVICES?

YES  NO If yes, When/Where \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

Do you have private medical/hospital insurance, Medicare or Medicaid?

YES  NO If yes, \_\_\_\_\_  
(type) (company)

HAVE YOU EVER BEEN CONVICTED OF A FELONY?  YES  NO

If yes, Please Explain: \_\_\_\_\_

DO YOU HAVE CHARGES PENDING?  YES  NO

If yes, please Explain: \_\_\_\_\_

ARE YOU A VETERAN?  YES  NO IS DISABILITY CONNECTED?  YES  NO

If yes, please specify: \_\_\_\_\_

DO YOU HAVE A RELIABLE VEHICLE?  YES  NO Number of Vehicles? \_\_\_\_\_

TOTAL NUMBER OF FAMILY IN THE HOME \_\_\_\_\_

LIST ALL HOUSEHOLD MEMBERS WITH MONTHLY INCOME INFORMATION  
(Include Wages, VA, SSI, SSDI, TANF, Worker's Comp, Unemployment, etc.)

Name	Relationship	Source	Amount
	Self		

**HAVE YOU EVER BEEN DEFAULTED ON A STUDENT LOAN?**  YES  NO

If Yes, list status of student loan: \_\_\_\_\_

**LIST YOUR EDUCATION HISTORY: High School/GED**

\_\_\_\_\_  
(School Name) (Grade Completed/GED Certificate) (Dates)

**Technical**

\_\_\_\_\_  
(School Name) (Grade/Certificate Completed) (Major)  
(Dates)

**College/University**

\_\_\_\_\_  
(School Name) (Hours Completed) (Area of Study) (Dates)

**LIST LAST THREE JOBS:**

1. \_\_\_\_\_  
(Job Title) (Employer Name) (Dates MM/YY- MM/YY)

\_\_\_\_\_  
(Reason for leaving) (Beginning Wages) (Ending Wages)

2. \_\_\_\_\_  
(Job Title) (Employer Name) (Dates MM/YY- MM/YY)

\_\_\_\_\_  
(Reason for leaving) (Beginning Wages) (Ending Wages)

3. \_\_\_\_\_  
(Job Title) (Employer Name) (Dates MM/YY- MM/YY)

\_\_\_\_\_  
(Reason for leaving) (Beginning Wages) (Ending Wages)

**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: \_\_\_\_\_

**CHEROKEE NATION CAREER SERVICES  
VOCATIONAL REHABILITATION**

**STATEMENT OF INCOME AND LIABILITIES**

**I. Assets**

A. Are you or a household member working full –time or part-time and earning money?

YES  NO If yes, complete the following:

Employed Person	Place of Employment	Monthly Income
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Employed Person	Place of Employment	Monthly Income
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B. Do you or any household member have income other than earned income?

Yes  No

If yes, complete the following:

INCOME	AMOUNT	INCOME	AMOUNT
<b>Social Security</b>	\$	<b>Assistance Payments-TANF</b>	\$
<b>SSDI</b>	\$	<b>Unemployment Benefits</b>	\$
<b>SSI</b>	\$	<b>Retirement Pension</b>	\$
<b>Aid to Disabled thru DHS</b>	\$	<b>Business Income/Farm Income</b>	\$
<b>Workers Compensation</b>	\$	<b>Property</b>	\$
<b>Child Support/Alimony</b>	\$	<b>Other Income</b>	\$
<b>Tribal Benefits</b>	\$	<b>VA Benefits:</b>	\$
<b>Explain Tribal Benefits:</b>			

C. Other available resources (Give total amount in account – not interest earnings).

<b>Checking Account</b>	<b>\$</b>
<b>Savings Account</b>	<b>\$</b>

**II. MEDICAL DEBTS**

Do you or any household member have any medical expenses? YES NO

If yes, complete the following:

Hospital	\$
Medication Payment	\$
Medical Insurance Payment	\$
Disability Related Expenses	\$
Physicians	\$

**III. Other Debts:**

A. Other family members attending post-secondary school:

Family Member	School	Tuition, Fees, Books

B. Other debt, court ordered commitments/child support etc. Include types of debt and monthly amount. \_\_\_\_\_

\_\_\_\_\_

**\* All information provided above must be verified with appropriate documents.**

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**CONSUMER RESPONSIBILITIES**

I certify that the information I have given is true, correct and complete to the best of my knowledge. I agree to notify my Rehabilitation Counselor within **30 days**, if I have a change in my **living arrangements, address, income, automobiles, and other resources of any kind, expenses or needs**. Upon notification of such changes, I understand my case will be reviewed and revised to reflect any new information.

I understand that the information I have given will be carefully reviewed and that I might be asked to provide proof of the answers given. I further understand that any false statements make me subject to prosecution for fraud. I hereby authorize the Cherokee Nation Career Services Vocational Rehabilitation Program to make any necessary investigation to verify the information I have given.

I understand if I falsified any information, services through Cherokee Nation Career Services Vocational Rehabilitation Program will notify me of this decision and I will have **(5) working days** to respond. If no acceptable response, explaining the circumstance, is received in the Cherokee Nation Career Services Vocational Rehabilitation Program office, within **30 days**, services may be discontinued.

**I also agree to provide employment verification, to my VR counselor, once my training is complete and an employment outcome has been achieved.**

\_\_\_\_\_  
**Consumer/Representative Signature**

\_\_\_\_\_  
**Date**

**CHEROKEE NATION CAREER SERVICES  
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**GENERAL HEALTH CHECKLIST**

**Please answer "YES" or "NO" to all items.  
Do you have.....**

**If yes, has it kept  
you from working?**

	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
1. A disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Frequent dizziness, fainting, headaches, seizure, paralysis, or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Disorder of kidney, bladder, prostate, or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes, thyroid, or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis, or other disorder of the muscles or bones including the spine, back, or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Absence or amputation of any body parts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Loss of use of arms, legs, or other body parts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. A tumor, cancer, disorder of skin or lymph glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Anemia or other disorders of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Excessive use of alcohol or any habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Any other physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes specify \_\_\_\_\_

17. Name and address of your personal physician/clinic: \_\_\_\_\_  
\_\_\_\_\_

**ANSWER QUESTIONS FOR ANY CONDITIONS MARKED "YES" ON THE FIRST PAGE.**

18. Have you ever been or are you being treated for any of these conditions?  
If NO, why not? \_\_\_\_\_  
If YES,

Condition	Dr. Name & Address	Phone Number	Dates Seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

19. Have you ever been hospitalized for any of these conditions?  
If YES,

Condition	Hospital	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. Are you taking medicines? (Attach list if needed)  
If YES,

Condition	Medicine	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

21. Do you have any restrictions on these conditions?  
If Yes,

Condition	What Restrictions?
_____	_____
_____	_____
_____	_____

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

\_\_\_\_\_  
**Consumer Signature** \_\_\_\_\_  
**Date**

Person who provided information, if not applicant: \_\_\_\_\_



# AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_\_\_ Record No. \_\_\_\_\_

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

**Name of Agency and Individual to Receive PHI:**

Cherokee Nation Vocational Rehabilitation  
Attention:  
P.O. Box 948  
Tahlequah, OK 74465

**Name of Individual/Facility to Disclose PHI:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Portions to Release are:**

Medical       Psychological       Vocational       other (specify) \_\_\_\_\_

Date (s) of Service: \_\_\_\_\_

This information shall be obtained, used or disclosed for the **following purpose(s)** only

Establish eligibility for rehabilitation services       Develop a vocational program for consumer

**The information I authorize may include records which may indicate the presence of a communicable or non-communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus, also know as Acquired Immune Deficiency Syndrome (AIDS). I understand that these records may include psychiatric, alcohol and drug abuse information, occupation information, or information regarding other insurance coverage. I specifically authorize the release of my drug, alcohol and/or mental health treatment records. The information obtained with this disclosure form is required to be kept confidential by the Cherokee Nation Vocational Rehabilitation Program under Federal Law 34CFR 361.38.**

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by the law.

**Right to revoke: I may revoke this authorization by sending a written request to the Cherokee Nation Vocational Rehabilitation Program at the address listed above. Revocation will not apply to information already used or disclosed in response to this authorization.**

**Termination date: This Authorization expires (12) months following the date signed.**

**Consumer:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian/Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

