Vocational Rehabilitation Program
P.O. Box 908 Lawton, Oklahoma 73502
Phone: 580-492-3605 Fax 580-699-7241
Email: voc-rehab@comanchenation.com

Application

(please complete pages 1-6)

In order for Comanche Nation Vocational Rehabilitation to assist you, Federal Law states we must have verification of Disability. This verification form, **"Documentation of Disability",** is included in the application (page 7). This form must be completed and signed by a Doctor. **Consumer is the Applicant**

Consumer Name:_____

Consumer Physical Address:

_____ _____ _____ _____
Street Address City /Town Zip Code County

Mailing Address:_____ _____ _____
P.O. Box City / Town Zip Code

Date of Birth:_____ Tribe:_____ CDIB #:_____

Telephone Number:_____ Email Address:_____

Marital Status:_____

Number in Household:_____

Name:_____ Name:_____ Name:_____

State your Disability and describe how your disability effects your ability to work:

_____

_____

When did your disability occur?_____And do you receive Disability Benefits? Yes____ No____
Are you currently being treated for your disability? Yes_____ No_____
If you answered No, please explain why:

_____

_____

Name of Provider of Treatment	Address (include City & Zip)	Telephone Number	Date Last Seen

Have you every been convicted of a Felony? Yes_____ No_____
If you answered Yes, please state the conviction and the outcome of your conviction.

_____

_____

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Work History:

Employer Name (last 3 jobs)	Job Title	Job Duties	Dates of Employment: (Beginning & Ending)	Date & Reason for Leaving

Educational History:

Type of Institution	Name of Institution	Address	Course of Study	Year Graduated
High School			High School Diploma	
GED			High School Equivalency Certificate	Date Received:
College				
Technical School				

Do you currently have a Student Loan in Default? Yes_____ No_____
If answered Yes, Name of Institution:_____

Are you currently receiving Workman's Compensation? Yes_____ No_____
If answered Yes, please explain:

_____

_____

Are you a veteran or currently a member of the military? Yes_____ No_____

Branch of Service and dates_____
Is your Disability related from being in the Service? Yes_____ No_____

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General Health Checklist

Please check the specific condition listed that applies:

Do you have?	YES	NO	How this condition effected your job performance
1.A disorder of the eyes, ears, nose or throat			
2.Frequent fainting, dizziness or headaches			
3.Seizures, convulsions, paralysis or stroke			
4.Persistent coughing, bronchitis, asthma, emphysema, tuberculosis or other disorder of the lungs			
5.Chest pain, high blood pressure, rheumatic fever, murmur, heart attack or other disorder of the heart or blood vessels			
6.Intestinal bleeding, ulcer, hernia, colitis, other disorder of the intestines, liver or gallbladder			
7.Disorder of Kidneys, bladder, prostate or reproductive system			
8.Diabetes, thyroid 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 or legs or other body parts			
11.A tumor, cancer or disorder of skin or lymph glands			
12.Allergies			
13.Anemia or other disorder of the blood			
14.Excessive use of alcohol or other habit-forming drug			
15.Behavior Health issues such as Depression, Anxiety, or bipolar			
15.Other physical or behavior health condition (specify)			

Do you have medical insurance, including Medicaid and / or Medicare? Yes_____ No_____
If yes, please state Name and Type of insurance:

_____

_____

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Are you currently taking any medications? Yes_____ No_____
If you answered yes, please complete the following:

Name of Medication	What does medication assist with?

Consumer's Monthly Income:_____

Household Income including Consumer:

Name	Relationship to you	Source of income	Monthly income

TOTAL:_____

Please list three contacts we may be able to contact, if we are not able to contact you:

Name	Address	Telephone Number	Relationship to you

How did you learn about Comanche Nation Vocational Rehabilitation?_____

_____

How may Comanche Nation Vocational Rehabilitation assist you?

_____

_____

You may sign the application, **BUT please do not date this application till you have an interview with a counselor face-face. Thank You.**

Consumer/Applicant Signature:_____ Date:_____

Counselor Signature:_____ Date:_____

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Consent for Release of Confidential Information

I,_____, authorize Comanche Nation Vocational Rehabilitation Program to
(Consumer Print Name)
disclose the following information and receive the following information:

Medical_____ Psychological_____ Vocational_____
School Records_____ Employment_____

Other and/ or specify a particular program/agency.

_____

_____

The disclosure authorized in this consent is for the purpose of retrieving information needed in applying for Comanche Nation Vocational Rehabilitation Program. Updates may also be provided to Comanche Nation Vocational Rehabilitation Program in order to continue to be served. Disclosure authorizes a release to other Comanche Nation programs or other agencies for their program purpose. Also, may release personal information in order to protect the individual or others if the individual poses a threat to his or her safety or to the safety of others.

Such purpose and need for the release of information is to:

Establish eligibility for rehabilitation services_____
Develop a vocational program_____
Determine need for and/or type of treatment_____
Case staffing_____
Family/next of kin contact_____
Other_____

The information I authorize for lease may include information that could be considered information about communicable or venereal diseases which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known Acquired Immune Deficiency Syndrome (AIDS). Information in your records that you may have communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court or the department of health, release among health care providers or release for statistical or epidemiological purposes. When such information is released it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by order of the court or the department of health by law.

This release may be revoked at any time with a written request. This release expires upon closure of case, unless otherwise indicated.

Consumer/Applicant Signature:_____ Date:_____

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A. STATEMENT OF NO INCOME (complete only, if you have NO income)

I certify that I have **NO** income at this time. If, this changes I will inform my counselor of the change within 10 days.

Consumer's signature_____ Date_____

B. STATEMENT OF RESIDENCY (complete only, if you reside with someone in their home)

To ensure services can be provided to the applicant, **Verification of Residence** is one of the requirements in applying for Comanche Nation Tribal Vocational Rehabilitation Program. Consumer must reside in our nine (9) county service area.

The consumer states he/she resides in your household and you are the Head of Household. As Head of Household, you are asked to verify the consumer in fact does reside with you at your address. Please complete the following information:

I certify that _____resides with me/us at the address listed below.
(consumer's name)

Physical address:_____

_____

Head of Household signature:_____ Date:_____

Consumer signature certifies address is correct and he or she will inform their counselor of a change of address within 10 days.

_____ Date:_____
(consumer signature)

C. For consumer information, application is considered **incomplete** until all the following **required** documents have been submitted with your application:

(1) CDIB
(2) Social Security Card
(3) Driver License (current)
(4) State I.D. (current) if you have no Driver License
(5) Verification of Disability
(6) Verification of Income
(7) Verification of Residence

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Documentation of Disability

Consumer/Applicant Name:_____ DOB:_____

Dear Doctor:

The above individual has made application for rehabilitation services. In order to assist this applicate we are required by Federal Law to verify this individual has a substantiated disability which results in an impediment to employment.

The CNVRP is mandated by Federal Law to determine this individual's eligibility within (60) days. Therefore, we are asking for your assistance in providing answers to the following health questions.

DIAGNOSIS: Please describe the disabling condition(s)_____

_____

Interpretation of the diagnosis in relation to the way it affects the patient: Indicate any secondary physical, mental, psychological, chemical dependency difficulties that affects the individual's capacity to engage in an employability plan.

_____

_____

PROGNOSIS: _____

RECOMMENDATION FOR TREATMENT: Can this individual's condition be improved through treatment?

YES____ NO___ If YES, what type of treatment is recommended?_____

_____

FUNCTIONAL LIMITATIONS: Please list all limitations and restrictions created by this disability._____

_____

IS THE PATIENT EMPLOYABLE AT THE PRESENT TIME? YES_____ NO___ Please state a justification as to your answer.

_____

THIS FORM MUST BE FILLED OUT AND SIGNED BY A MEDICAL DOCTOR, NOT A PHYSICIAN ASSISTANT.

Printed Name of Doctor: _____ Date:_____Telephone: _____

Signature of Doctor: _____Address: _____