

**Cherokee Nation**  
**Vocational Rehabilitation**  
Phone (918) 453-5004 Fax (918) 458-4482  
[vocational\\_rehab@cherokee.org](mailto:vocational_rehab@cherokee.org)

**DOCUMENT CHECKLIST**

In order to complete the application process, the applicant must provide at least one form of documentation for each of the following areas indicated.

DOCUMENTS REQUIRED:

- PROOF OF INCOME (Include income for all household members)**

*Examples: Social Security Award Letter, VA Award Letter, Copy of Benefit Check, Income Verification from DHS (TANF), Pay Stubs, Letter from Employer, etc.*

- PROOF OF TRIBAL CITIZENSHIP**

*Examples: Tribal Citizenship Card from Federally Recognized Tribe, Letter from Agency (BIA), etc.*

- PROOF OF PHYSICAL ADDRESS (P.O. BOX NOT ACCEPTED)**

*Examples: Utility Bill, Driver's License, Rent Receipt, etc.*

- PROOF OF DISABILITY**

*Examples: Medical/Psychological Records (last 3 years), School Assessment Records (IEP)*

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**APPLICATION**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: N/A Gender:  Male  Female

Tel./Cell Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

County: \_\_\_\_\_ Email Address: \_\_\_\_\_

What is your disability? And when did it occur? (Month & Year)

How does your disability limit your ability to work or obtain employment?

My signature to this document constitutes an application for rehabilitation services. In order 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. Failure to provide this information may prevent the rehabilitation program from providing services in a timely manner.

***CONSUMER RIGHTS AND REMEDIES***

I have been advised of the availability of the Client Assistance Program (CAP) and have received a brochure explaining the purpose of the CAP office. For assistance call 1-800-522-8224.

I understand that I may request an administrative review if I do not agree with a decision made by my counselor. An administrative review may be requested by contacting the Cherokee Nation Vocational Rehabilitation Program Manager verbally or in writing within 30 days of the effective date of the decision.

Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Voc Rehab Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Have you ever applied for or received State or Tribal Vocational Rehabilitation services?  Yes  No

If yes, When/Where?

Do you have a ticket to work?  Yes  No

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: \_\_\_\_\_

Have you used any alternate names?  Yes  No

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

Do you have a reliable vehicle?  Yes  No      Number of Vehicles: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow(er)  Separated

Total number living in your home: \_\_\_\_\_

List all household members with monthly income (include those with wages, VA, SSI, SSDI, TANF, Worker's Comp, Unemployment, etc.)

Name	Relationship	Income type	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you or any household member receiving any other tribal benefits?  Yes  No

If yes, please explain: \_\_\_\_\_

**EDUCATION & WORK HISTORY**

Have you ever been defaulted on a student loan?  Yes  No

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

**EDUCATION HISTORY**

**High School/GED**

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

**Technical**

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

**College/University**

\_\_\_\_\_  
(School Name) (Hours Completed/Course of Study) (Dates)

**EMPLOYMENT HISTORY**

(List 3 most recent jobs)

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

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

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

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

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

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

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**CONSUMER RESPONSIBILITY STATEMENT**

(Please read carefully)

I certify that the information I have given is true, correct, and complete to the best of my knowledge.

I understand that the Cherokee Nation Vocational Rehabilitation Program has 60 days from the date of application to find me eligible or not eligible. After careful review of my full and complete application, including the required documents, I will be notified of a decision.

I agree to notify my Rehabilitation Counselor within 30 days, if I have a change in my living arrangements, address, telephone number, income, automobiles, or resources of any kind.

I agree to notify my Rehabilitation Counselor within 30 days, if I have a change in my 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. Furthermore, I understand that any false statements make me subject to prosecution for fraud. I hereby authorize the Cherokee Nation Vocational Rehabilitation Program to make any necessary investigations to verify the information I have given.

I understand if I falsified any information, services through the Cherokee Nation Vocational Rehabilitation Program may be suspended. I understand that I will be notified of the Program's decision and have 5 working days to respond. If no acceptable response, explaining the circumstance, is received, services will be cancelled and all costs incurred will be my responsibility.

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

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(Print Name)

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(Signature)

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(Date)

Revised 03/15/19

***Cherokee Nation  
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**HEALTH INFORMATION**

Do you have any of the following?	Please answer "Yes" or "No" to all		If yes, has it kept you from working?	
	Yes	No	Yes	No
1. A disorder of the 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 lung disorders	<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. Alcohol or substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Any other physical or mental condition not listed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been or are you currently being treated for any of these conditions?  Yes  No

Condition	Dr. Name/Facility	Address
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>



# AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ SS#: N/A DOB: \_\_\_\_\_

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/Individual to Receive PHI  
Disclose PHI:**

**Name of Facility/Individual to**

Cherokee Nation Vocational Rehabilitation

Attn: \_\_\_\_\_

P.O. Box 948

Tahlequah, OK 74465

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

Portions to be released (check all that apply):

- Medical                       Psychological                       Other (Specify): \_\_\_\_\_

Date(s) of Services:

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

- Establish eligibility for rehabilitation services       Develop a vocational program

The information I authorize may include records which may indicate the presence of a communicable or noncommunicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus, also known 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Revised 03/15/19