PLEASE PROVIDE THE FOLLOWING DOCUMENTATION:

- SOCIAL SECURITY CARD
- PROOF OF ENROLLMENT IN A FEDERALLY RECOGNIZED TRIBE
- DRIVER’S LICENSE OR STATE-ISSUED ID
- PROOF OF RESIDENCY (Utility Bill, Rent Receipt, Lease Agreement or Residence Verification Form)
- PROOF OF DISABILITY (Documentation of Disability Form)

Cheyenne and Arapaho Tribal Vocational Rehabilitation (CATVR) has 60 days to determine your eligibility. If you have not submitted the required information within 60 days, your case will be closed as “ineligible”.

If further information is needed to help make a decision regarding your disability, an extension may be granted.

CONCHO OFFICE LOCATION:

100 RED MOON CIRCLE, CONCHO, OK. 73022

DIRECTOR: Timothy Yeahquo, Jr.
ADMINISTRATIVE ASSISTANT: Susie Galindo
COUNSELOR: Yolanda Woods

PHONE: (405) 422-7617
TOLL FREE: (888) 284-7725
FAX: (405) 422-8213
EMAIL: tyeahquo@c-a-tribes.org
EMAIL: sgalindo@c-a-tribes.org
PHONE: (405) 422-7697
EMAIL: ywoods@c-a-tribes.org

WATONGA OFFICE LOCATION:

110 N. NOBLE, WATONGA, OK. 73772

COUNSELOR: Fred Mosqueda

PHONE: (580) 623-7325
TOLL FREE: (866) 623-7325
FAX: (580) 623-7314
EMAIL: fmosqueda@c-a-tribes.org

CLINTON OFFICE LOCATION:

2015 DOG PATCH RD., CLINTON, OK. 73601

COUNSELOR: Lori Seitter-Lee

PHONE: (580) 331-2320
FAX: (405) 422-8213
EMAIL: lseitter-lee@c-a-tribes.org
CHEYENNE & ARAPAHO TRIBES
VOCATIONAL REHABILITATION
DOCUMENT LIST

Applicant must provide at least one form of original documentation from the following list:

DOCUMENTS REQUIRED

1. __PROOF OF INCOME (Include all income for all household members)
   A. Social Security Award Letter or VA Award Letter
   B. Copy of benefits check(s)
   C. Income verification from the Department of Human Services (DHS) or a letter stating what services you are receiving
   D. Copy of most recent check stub

2. __PROOF OF TRIBAL ENROLLMENT
   A. CDIB card with roll number & which Federally Recognized Tribe you are enrolled with

3. __PROOF OF AGE
   A. Birth Certificate
   B. Driver’s License or State Issued ID

4. __PROOF OF SOCIAL SECURITY NUMBER
   A. Social Security Card

5. __PROOF OF MAILING ADDRESS/VERIFICATION OF RESIDENCY
   A. Utility Bill (gas, electric or water) in your name
   B. Current Driver’s License or State Issued ID
   C. Current Rent receipt or Lease Agreement in your name
   D. Voter’s registration card
   E. Residence Form (included in application packet) completed by the person you live with as well as one of the above in their name

6. __PROOF OF DISABILITY
   A. Completed Documentation of Disability Form (included in application packet) from the appropriate professional

Form Revised 11.29.17
APPLICATION FOR SERVICES

1. I UNDERSTAND THAT IN ORDER TO RECEIVE VOCATIONAL REHABILITATION SERVICES, I MUST HAVE:

   A. A physical or mental capacity which interferes with my ability to find or maintain employment, and

   B. A reasonable chance to be able to work after I receive services.

2. If I am eligible for services, I understand my Counselor will involve me in planning my rehabilitation program and my program 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 rehabilitation goals. I understand I must keep scheduled appointments.

3. I understand that rehabilitation services are dependent upon the availability of openings and funds with the Cheyenne and Arapaho Rehabilitation program, as well as with the Oklahoma Department of Rehabilitation Services (DRS) for assistance.

4. I am aware that I have the right to appeal decisions made by the Rehabilitation program staff by requesting a meeting with the Director, verbally or in writing, within 30 days of the effective date of the decision. I also understand that I may continue to appeal any grievance beyond the Director, provided that I have made this request within 30 days of the Director’s decision.

5. I understand that all information will be treated in a confidential manner.

THIS FORM HAS BEEN REVIEWED WITH ME AND I HAVE BEEN GIVEN A COPY.

Applicants Signature or Representative (if applicable) ____________________________ Date ____________________________

Form Revised 11.29.17
CLIENT INFORMATION

NAME:__________________________________________________________

(LAST) (FIRST) (M.I.)

SOCIAL SECURITY NUMBER: ________________________________

TELEPHONE NUMBER: ________________________________ (ALTERNATE)

EMAIL ADDRESS: __________________________________________

DOB: ___________ SEX: __MALE __FEMALE

TRIBAL AFFILIATION: ________________________________ CDIB: __YES __NO

HOW MANY PEOPLE LIVE IN YOUR HOME? __________

HOME ADDRESS: __________________________________________ (STREET, ROUTE OR PO BOX, CITY, STATE & ZIP CODE)

FINDING DIRECTIONS IF RURAL AREA:

______________________________________________________

______________________________________________________

COUNTY OF RESIDENCE: __________________________

GUARDIANS NAME (IF APPLICABLE):

______________________________________________________

& RELATIONSHIP TO APPLICANT (LAST) (FIRST) (M.I.)

WHAT IS YOUR DISABILITY, HOW DOES IT LIMIT YOUR ABILITY TO WORK AND WHAT SERVICES DO YOU NEED:

______________________________________________________

______________________________________________________

DO YOU HAVE MEDICAL INSURANCE THROUGH YOUR EMPLOYER? __YES __NO

COMPANY NAME: ________________________________

POLICY GROUP NUMBER: ________________________________

DO YOU HAVE PRIVATE MEDICAL INSURANCE OR MEDICARE AND/OR MEDICAID? __YES __NO

IF YES LIST TYPE: ________________________________ POLICY GROUP NUMBER: ________________________________

Form Revised 11.29.17
LIST THE MEMBERS OF YOUR HOUSEHOLD WITH INCOME: (SSI, SSDI, SOCIAL SECURITY, PUBLIC ASSISTANCE, WORKERS COMP, EMPLOYMENT, ETC...)

<table>
<thead>
<tr>
<th>NAME:</th>
<th>RELATIONSHIP/Self:</th>
<th>SOURCE:</th>
<th>AMOUNT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HAVE YOU EVER APPLIED FOR REHABILITATION OR VISUAL SERVICES?
__YES (IF SO), WHEN & WHERE? _____________________________  __NO

HAVE YOU EVER BEEN SEEN BY A DOCTOR FOR PROBLEMS RESULTING FROM YOUR DISABILITY?
__YES (IF SO PLEASE PROVIDE THAT INFORMATION):  __NO

1. __________________________________________________
   (DR.'S NAME AND ADDRESS)  (TELEPHONE NUMBER)
   (DATES SEEN)  (REASON SEEN)

2. __________________________________________________
   (DR.'S NAME AND ADDRESS)  (TELEPHONE NUMBER)
   (DATES SEEN)  (REASON SEEN)

DID YOU GRADUATE FROM HIGH SCHOOL OR RECEIVE A GED?
__YES  (IF SO WHERE AND WHEN)  __NO

EDUCATION HISTORY (COLLEGE/UNIVERSITY, TECHNICAL, OTHER)

<table>
<thead>
<tr>
<th>(NAME OF SCHOOL)</th>
<th>(ADDRESS)</th>
<th>(CITY/STATE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>(HOURS COMPLETED)</th>
<th>(MAJOR)</th>
<th>(DATES ATTENDED)</th>
</tr>
</thead>
</table>
EDUCATION HISTORY CONTINUED:

(NAME OF SCHOOL) (ADDRESS) (CITY/STATE)

(HOURS COMPLETED) (MAJOR) (DATES ATTENDED)

HAVE YOU EVER DEFAULTED ON A STUDENT LOAN?  ___YES  ___NO

LIST YOUR LAST TWO (2) JOBS:

1.  
   (JOB TITLE) (EMPLOYER & ADDRESS) (WEEKLY EARNINGS)

   (DATES EMPLOYED) (REASON FOR LEAVING)

2.  
   (JOB TITLE) (EMPLOYER & ADDRESS) (WEEKLY EARNINGS)

   (DATES EMPLOYED) (REASON FOR LEAVING)

LIST TWO (2) PEOPLE WHO WILL ALWAYS KNOW HOW TO LOCATE YOU:

1.  NAME: __________________________ RELATIONSHIP: ________________________

   ADDRESS: ______________________ TELEPHONE: ______________________

2.  NAME: __________________________ RELATIONSHIP: ________________________

   ADDRESS: ______________________ TELEPHONE: ______________________

ARE YOU A VETERAN?  ___YES  ___NO

DO YOU PARTICIPATE IN NATIVE AMERICAN CEREMONIAL ACTIVITIES?  IS SO, PLEASE EXPLAIN:

____________________________________________________________________

WHO REFERRED YOU TO OUR OFFICE?

____________________________________________________________________

Form Revised 11.29.17
RESIDENCE VERIFICATION FORM

This document is to verify that ______________________________ resides at
____________________________ in the city of ____________________________
and the county of ____________________.

I certify that I am the owner of the residence and/or the owner of the lease to the
residence at ______________________________. I offer the attached document as
verification of this residence and I testify that ______________________________ resides in my
residence on a permanent basis. My relationship to the client is: ____________________.

Type of Verifying Document: ____________________________________________

Signature of Residence Owner: ______________________________ Date: __________
Signature of Consumer: ______________________________ Date: __________
Signature of Counselor: ______________________________ Date: __________
Cheyenne and Arapaho Tribes Vocational Rehabilitation Program

NAME: ___________________________ DATE OF BIRTH: ___________ SSN#: ___________________________

Dear Doctor:

The above individual has submitted an application for rehabilitation services. In order to assist the applicant, I am required by Federal Law to verify that this individual has a substantial disability which results in an impediment 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 disabiling condition(s) and supply the appropriate diagnosis, including diagnostic codes (either ICD-9 or DSM-IV codes). ___________________________

(2) Prognosis: ___________________________

(3) Recommendation(s) for treatment: Can this individual’s condition be improved through treatment?
   __Yes    __No    __Unknown (if yes what type of treatment is recommended)?
   ___________________________

(4) Functional Limitation(s): Please list all limitations and restrictions created by this disability.
   ___________________________

(5) Recommendations for individual’s Vocational Rehabilitation plan: ___________________________

THANK YOU FOR YOUR ASSISTANCE

*Physician Signature: ___________________________ Date: ___________

Physician Name (please print): ___________________________ Date: ___________

*A MENTAL HEALTH PROFESSIONAL MAY ALSO FILL THIS FORM OUT FOR A PSYCHOLOGICAL DISABILITY.

Form Revised 11.29.17
CHEYENNE & ARAPAHO TRIBES VOCATIONAL REHABILITATION AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

CONSUMER NAME: ____________________________________________

CONSUMER ID NUMBER: _____________________________________

CONSUMER ADDRESS (include apartment # and/or building (if applicable)

The office of the Cheyenne & Arapaho Tribes Vocational Rehabilitation Program (CATVR) has my permission to release or obtain information indicated in item #1 below.

This information may include reports about my physical or mental condition, school records, facts necessary to determine my financial need, or other information that CATVR needs to determine my eligibility for Vocational Rehabilitation services.

I understand that information disclosed according to this consent may be subject to re-disclosure and will no longer be subject to the HIPPA privacy requirements.

I can change my mind about this release, by telling CATVR in writing that I do not want any further information to be disclosed. This will not affect actions already taken with my permission.

My permission to release or obtain information expires on date __________ or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released or obtained? Be specific.
   __________________________________________________________

2. Who is releasing this information? (Insert the full name of this person or organization).
   __________________________________________________________

3. Who is receiving this information? (Insert the complete information about this person or organization).
   Name: ____________________________________________
   Title: ______________________________________________
   Address: ____________________________________________

Why is this information needed? ____________________________________________

I have read all of the information on this form and understand and agree to the requirements.

Consumer or Representative (if applicable) Signature: ________________________________

Date: __________________________

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records.