Tanana Chiefs Conference

122 1ST Ave. Suite 600
Fairbanks, AK 99701
907-452-8251

TRIBAL VOCATIONAL REHABILITATION

APPLICATION FOR REHABILITATION SERVICES

Note: ***All information provided is confidential and can only be used for furtherance of the Applicant's Vocational Rehabilitation planning.***

1. Name: _____
(First) (Initial) (Last) (Previous Name)
2. Home Address: _____
(Street) (City) (Zip Code)
3. Mailing Address: _____
(Street address) or P.O. Box (City) (Zip Code)
4. Social Security #:_____ 5. Birthdate _____

5. Marital Status: Married Single Divorced Widowed

6. Home Phone (or Message Phone):_____

7. Name 2 people (not living with you) who will always know your address:

_____Phone_____

_____Phone_____

8. What is your disability? _____

9. What are your vocational interests **(your goal)**? _____

10. Who referred you to Vocational Rehabilitation? _____

11. Have you ever been a client with Vocational Rehabilitation **(State or Tribal)** before?
Yes _____No_____. **Please list the Program** _____.

By signing this application I am requesting services from Tanana Chiefs Conference Vocational Rehabilitation. I further certify that the information I have provided is correct.

Applicant Signature:_____Date_____
Parent or Guardian:_____Date:_____

Counselor's Signature:_____Date Received:_____

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Supplemental Application Information

VOCATIONAL

Starting with the most recent, list the jobs you have held:

A. Employer: _____

Dates of employment: _____ to_____Salary:_____

Job description: _____

Reason for leaving:_____

B. Employer: _____

Dates of employment: _____ to_____Salary:_____

Job description: _____

Reason for leaving:_____

HOUSEHOLD INFORMATION

1. Please list your dependents:

(Name) (Age) (Relationship)

_____

_____

_____

_____

2. Total number of dependents:_____Total number in household:_____

EDUCATION

1. High school graduate or GED?_____Where/when?_____
2. Starting with the most recent, list high school, trade school, college attended:

(School) (Degree/Certificate) (Date Attended)

_____

_____

_____

3. Were you enrolled in Special Education?_____
4. Have you ever defaulted on a Student Loan? Yes____ No_____

If Yes, list the status of the student loan:_____

* *If available, submit copies of degrees/certificates earned and transcripts.*

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Supplemental Application Information

FINANCIAL

1. Do you receive any assistance from the following sources (**this does not affect eligibility**)?

(Source)	(Type)	(Amount)
Adult Public Assistance		_____
Social Security/SSI		_____
Retirement benefits		_____
Worker's Compensation		_____
Annuity or private insurance		_____
Veteran's benefits		_____
ASHA Housing		_____

2. How long have you received the benefits indicated above? _____
3. What is your primary source of support?_____
4. Total household income:_____
5. If you are a Veteran, note branch of service, type of discharge, period served._____

   _____
6. If employed at time of application, weekly earnings?_____
7. Are you a member of any Labor Union?_____

MEDICAL

1. List the doctors and hospitals familiar with your condition:

(Name)	(Address)	(Date last seen)
_____		
_____		
_____		

2. Are you taking any type of medication?_____If so, please note what type and who is the prescribing physician?_____
3. Are you receiving personal care attendant services?_____Hours/Day_____

LEGAL

1. Do you have a valid Alaska Driver's license? Copy of license_____
2. Do you have your own transportation? Copy of registration/insurance_____
3. Have you ever been arrested or convicted?_____
4. Are you currently on probation or parole?_____If so, who is your probation or parole officer?_____

Please attach a copy of your Tribal Enrollment Card

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AUTHORIZATION FOR USE AND DISCLOSURE OF SPECIFIED INFORMATION

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Patient Name: _____Date of Birth: _____

Patient Telephone:_____

I authorize the following person to disclose /obtain employment/education information to/from the following :

Info FROM: Person/Organization/Facility:	**Info TO:** Person/Organization/Facility: TCC Tribal Voc Rehab Program staff (Amanda Race/Phillip Albert)
Address:	Address: 122 First Avenue, Suite 600, Fairbanks, 99701
Contact Number:	Contact Number: 907-452-8251 x3232
Fax Number:	Fax Number: 907-459-3833

Date of Service/s: From: _____ To: _____

Consumer ***must*** initial the specific confidential information:

___Other: (please specify)_____
The purpose or need for this disclosure is:

□ Eligibility Determination □ On-going Case Management □ IPE Development □ Other; please specify _____

The information may be transmitted via (consumer ***must*** initial each approved communication method)
_____ fax _____ verbal _____electronically (***required*** to complete duty to warn) _____hard copy

- I understand that if the person or entity that receives the health information is not a health care provider or health plan covered by federal privacy regulations, the health information above may be subject to redisclosure and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by notifying the Privacy Official except to the extent that action has been taking in reliance on this authorization.
- **Unless revoked, this authorization will expire 6 months from the date signed or as specified:**
  _____
- I may inspect or copy any information used/disclosed under this authorization. I have received a copy of this authorization.

I further acknowledge that the information to be released has been explained to me and certify that this consent is given on my own free will.

_____ _____
Signature of Patient or Legally Designated or Personal Representative Date

_____
Please print name of Legally Designated or Personal Representative (if applicable)
If not signed by Patient, description of authority: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF SPECIFIED INFORMATION

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Preferred Method of Communication: Duty to Warn

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means or at alternative locations and we will accommodate reasonable request/s.

Name of Client: _____Today's Date: _____
Date of Birth: _____

You do not need to tell us why you are making this request.

You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication.

If You Prefer Email, Telephone Messages or Fax

You may request that we communicate with you by email, telephone message and/or fax. We must warn you there is some level of risk that protected health information transmitted by unencrypted email and/or unsecured fax could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email and/or unsecured fax we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.

You may check one or more boxes below or if your preference is not listed please provide specific directions in the space provided following the check boxes.

I request you communicate with me by:

1. **Telephone**
   - **Call my Home Phone**- Number_____

   (Please select a box)

   ☐ This is my preferred method of communication and is okay to leave a detailed message.

   ☐ This is my preferred method of communication, but do not leave a detailed message.
   - **Call my Cell Phone**- Number _____

   (Please select a box)

   ☐ This is my preferred method of communication and is okay to leave a message.

   ☐ This is my preferred method of communication, but do not leave a message.

Email:

Preferred Email Address: _____

Fax:

Preferred Fax Number: _____

I further acknowledge that this consent is given on my own free will.

Signature of Client Printed Name Date

Signature of Parent/ Legal Guardian *(if required)* Printed Name Date