NORTH INTERTRIBAL VOCATIONAL REHABILITATION PROGRAM (NIVRP)

INTAKE INFORMATION FORM

CONSUMER NAME: ______________________________ DOB: ____________

DATE APPLIED FOR SERVICES: ______________________________

PROOF OF TRIBAL ENROLLMENT IS REQUIRED: Tribe: ____________________

_____Copy of Tribal Enrollment Card/Documentation (in file)
_____Requested from Tribe **(Release Needed)**
_____Requested from ________________________

First time applying for VR Services: Yes No
If no, when and where ____
What brings this person in ____
What conditions are reported to affect her/his ability to work: ____________________________

____

How does this person believe these conditions prevent them from getting a job, keeping a job or performing the essential duties of their job ____
____

____

Currently employed with ______________________________ **as** _________________________
If unemployed, last job was____
Left this job because____
Primary occupation ______________________________ For how long? ____________________

Would this person: Return to this position Yes No
Return to this employer Yes No
Return to this line of work Yes No

Are there cultural/social activities, which limit availability for work? Yes No
If yes, explain: ____

Any assistive devices or other technology that would enable a return to work: _______________
____

MEDICAL BACKGROUND:
Are there any other conditions we should consider during the process of this case:

___ Vision/Hearing/Speech
___ High blood pressure
___ Blood Disorder
___ Allergies/rashes
___ Seizures/convulsions
___ Asthma/shortness of breath
___ Head Injury/stroke
___ Chronic Pain
___ Tumor/cancer
___ Stomach/intestines
___ Blackouts/fainting
___ Heart
___ Mobility
___ Insomnia
___ Headaches
___ Bowels

Has this person ever been unconscious? Yes No
If yes, please explain, briefly ____

Are there problems or concerns with any of the following:

___ Stamina/Strength	___ Remembering things	___ Stress
___ Following instructions	___ Working too slow	___ Math
___ Getting along with others	___ Anxiety or panic	___ Speech
___ Absences from work	___ Concentration	___ Coordination
___ Reading or writing	___ Anger or short temper	___ Depression

Is there history of treatment/therapy for emotional or mental health: Yes No
If yes, please explain ____

History of involvement with AA: Yes No
Currently? Yes No Times per week _________
Outpatient Counseling? Yes No With whom? _________________________________
Any inpatient treatment? Yes No Where/when: ________________________________
Is there another form of treatment which utilized to maintain sobriety? _____________________
____

Medications currently being taken ____
____

Use of any medically prescribed assistive aids (brace, cane, hearing aids) ___________________
____

Physicians/Specialists involved in care: **(Releases Needed)**

____
Name Address Dates

____
Name Address Dates

____
Name Address Dates

____
Name Address Dates

LEGAL BACKGROUND
Ever had a DWI? Yes No If yes, when? _______________

Ever had a felony conviction? Yes No If yes, please explain __________________
____

On probation/parole? Yes No If yes, who? _________________________________

EDUCATION BACKGROUND:
Highest grade completed __________________
___ High School Diploma ___ GED
___ College: Where ____
When ____
Program of Study____

Was/Is school difficult? Yes No If yes, how? ___________________________

Was this person placed in special education classes: Yes No

Does this person plan to further their education? Yes No

Explain ____

Any Certificates/licenses ____

LIVING SITUATION _____________________________ Stable? Yes No

Who all lives there? ____

____

Are Independent Living issues evident: Yes No

If yes, explain ____

MARITAL STATUS: Single Married Separated Divorce Partnership Widowed

REFERRED to VR by: ____

RELATIVES participating in NIVRP: ____

SUPPORT/COMPLIMENTARY SERVICES from: **(Releases Needed)**

___ Alcohol/Drug Treatment ___ Mental Health ___Veteran's Program

___ Developmental Disabilities ___ Employment Security ___ WIA/NEW/WIETTP

___ DSHS (TANF/GAU) ___ Social Security ___ Tribal GA

___ Labor and Industries (L&I) ___ Financial Aid ___ DVR/TVR

MEDICAL INSURANCE: Medicaid Medicare Employer I.H.S. Veteran's Other

TOTAL MONTHLY INCOME: $________________________

Source of Income: (Enter amount and frequency)

Wages $ ______________ per ______________

DSHS $ ______________ per ______________

SSI $ ______________ per ______________

SSDI $ ______________ per ______________

GA $ ______________ per ______________

Other $ ______________ per ______________ (please specify) ______________________

Wages needed to meet current obligations: ______________________________________

Unusual economic situation (fines, child support, etc) ____________________________

EMERGENCY CONTACT: ____

Name Phone Relationship

Are there any restrictions on when/how we may contact this person? _______________________

____

MILITARY SERVICE? Yes No If yes, what branch? __________________________

Dates of service ________________________ Discharge type ______________________

TRANSPORTATION: _________________________________ Reliable? Yes No

Valid Driver's License: Yes No If yes, what Number/State: ______________________

___ Revoked ___ Suspended ___ Restricted Explain: ________________________________

NEXT STEPS IN ASSESSMENT FOR ELIGIBILITY (**Releases Needed**):
___ Obtain existing medical information from: ____
___ Alcohol/Drug Evaluation: (when/where) ____
___ Psychological Evaluation: (when/where) ____
___ Vision Evaluation: (when/where) ____
___ Physical Evaluation: (when/where) ____
___ Hearing Evaluation: (when/where) ____
___ Other: ____

INFORMATION PROVIDED TO THE NEW APPLICANT:
___ Client Assistant Program/Brochure
___ VR Process Sheet
___ Sobriety requirements (if Alcohol/Drug related disability)
___ Financial Aid restrictions (if interested in school)
___ Job search information
___ Other ____

COMMENTS: ____

____

____

____

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I hereby apply to the North Intertribal Vocational Rehabilitation Program for services that will enable me to achieve an employment outcome. I understand that the information gathered in for this intake application will be used to gain the most information to provide me the best services in the North Intertribal Vocational Rehabilitation Program.

I authorize the North Intertribal Vocational Rehabilitation Program to gather information about me that is necessary to determine my eligibility for vocational services. * I understand that any information gathered about me will be kept confidential in accordance with 34 CFR 361.49 and will be released only with my consent and as necessary to achieve my rehabilitation.

I have received the information regarding my rights if at anytime I am dissatisfied with a decision made by the North Intertribal Vocational Rehabilitation Program including Administrative Review, and Impartial Due Process Hearing I can contact the Client Assistance Program (CAP) at 1-800-.

SIGNATURE OF APPLICANT: ______________________________ DATE: _______

SIGNATURE OF COUNSELOR: _____________________________ DATE: _______

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