 ***NORTH INTERTRIBAL***

 ***VOCATIONAL REHABILITATION***

  ***PROGRAM (NIVRP)***

##  INTAKE INFORMATION FORM

Participant Name  DOB 

Date Applied for Services: 

**LOCAL SERVICE AREA DOCUMENTATION (REQUIRED):**

Lives in service area: Yes[ ]  No [ ]

Type of Documentation used to establish Residency: 

**TRIBAL ENROLLMENT STATUS (REQUIRED):**

**Tribe:** **Enrollment Number:**

[ ]  Copy of Tribal Enrollment Card/Documentation (in file)

[ ]  Requested from Tribe **(Release Needed)**

[ ]  Requested from  **(Release Needed)**

Is this their first time applying for VR Services: Yes [ ]  No[ ]

If no, when and what program 

Referred to NIVRP by: Phone Number (if needed): 

What conditions are reported to affect her/his ability to work

How do these conditions prevent them from getting a job, keeping a job or performing the essential duties of their job?

What type of work does this person want to do:

How many hours a day can this person work?  How many days a week can this person work?  Any assistive devices or other technology needed to return to work:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employer/Job Title** |  **Dates of Employment** | **Rate of Pay** | **# hrs/week** | **Reason for Leaving** |
|   |   | $  |  |   |
|   |   | $ |  |   |
|   |   | $ |  |   |
|   |   | $ |  |   |
|   |   | $ |  |   |

Does this person participate in any cultural/traditional activities: [ ]  No [ ]  If yes, explain:

**MEDICAL BACKGROUND:**

Are there any other conditions we should consider during this process?

|  |  |  |
| --- | --- | --- |
| [ ]  Vision/Hearing/Speech [ ]  High Blood Pressure [ ]  Blood Disorder  [ ]  Allergies/Rashes [ ]  Seizures/Convulsions [ ]  Heart  |  [ ]  Head Injury/Stroke [ ]  Chronic Pain [ ]  Tumor/Cancer [ ]  Stomach/Intestines [ ]  Blackouts/Fainting  |  [ ]  Asthma/Shortness of Breath [ ]  Mobility [ ]  Insomnia [ ]  Headaches [ ]  Bowels  [ ]  Other  |
|   |  |  |
|  |  |  |

Has this person ever been unconscious? [ ]  Yes [ ]  No

If yes, briefly explain,

Has this person ever been hospitalized? [ ]  Yes [ ]  No

If yes, briefly explain

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

Medical Insurance: [ ]  Medicaid [ ]  Medicare [ ]  Employer [ ]  HIS [ ]  Veteran’s [ ]  Other:

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

Name Address Date Last Seen

  

Name Address Date Last Seen

  

Is there history of treatment/therapy for emotional or mental health: [ ] Yes [ ]  No

Provider and Date:

Medications currently being taken:

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

**SUBSTANCE USE HISTORY**

Currently in Recovery/Wellness or Medication Assisted Treatment Program? [ ] Yes [ ] No

If so, What Program?

Attended Outpatient Counseling? [ ]  Yes [ ] No Where/When

Attended Inpatient Treatment? [ ]  Yes [ ] No Where/when:

Is there another form of treatment which you utilize to maintain your recovery?

**LEGAL BACKGROUND**

Ever had a DUI? [ ] Yes [ ]  No If yes, when?

Ever had a felony conviction? [ ] Yes [ ]  No If yes, please explain:

Currently on probation/parole? [ ] Yes [ ]  No If yes, with where?

Have you ever been convicted of a sex crime? [ ]  Yes [ ]  No If yes, when?

**EDUCATION BACKGROUND**:

[ ]  High School [ ]  GED Highest grade completed 

|  |  |  |  |
| --- | --- | --- | --- |
| College | Dates Attended | Program of Study | Did you Receive a Degree? |
|       |        |       |       |
|       |        |       |       |
|       |        |       |       |

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

Did you have an IPE? [ ]  Yes [ ]  No

Does this person plan to further their education? [ ]  Yes [ ]  No Explain

Any Certificates /licenses 

**LIVING SITUATION**

 [ ]  Rent [ ]  Own [ ]  Permanent [ ] Temporary 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

Number of minor children responsible for: Do you owe child support?: [ ] Yes [ ] No Amount: $

**COMPARABLE SERVICES AND BENEFIT PROGRAMS:** **(Releases Needed)**

 [ ] Alcohol/Drug Treatment [ ] Mental Health [ ]  DVR/TVR

 [ ] Employment Security [ ] WIA/NEW/WIETT [ ]  Financial Aid

 [ ] DSHS (TANF/GA) [ ] Social Security [ ] Tribal TANF/GA

 [ ] Labor and Industries (L&I)

**TOTAL MONTHLY INCOME:**

Source of Income: (and frequency)

Wages $  per 

TANF $  per Month Enter amount

SSI $ per Month

SSDI $ per Month

GA $ per Month

Food Stamps $ per Month

Chile Support $ per Month

Other $ per (please specify)

Wages needed to meet current household obligations: $/hour

**MILITARY SERVICE**?

Yes No If yes, what branch?

Dates of service  Discharge type 

**TRANSPORTATION:**

Reliable? [ ] Yes [ ] No [ ] Own [ ] Public Transportation [ ] Bike [ ]  Borrow Vehicle

Valid Driver’s License: [ ]  Yes [ ]  No If yes, Number/State:  Revoked [ ]  Suspended [ ]  Restricted [ ]  Explain:

Do you Have Fines preventing you from getting you license: [ ] Yes; How much? $  [ ]  No

Current Insurance: [ ] Yes [ ] No

**EMERGENCY CONTACT: **

 Name Phone Relationship

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

Completed By:  Date: 