 ***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: 