



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

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

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
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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: _____

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:** _____
