Cherokee Nation
Vocational Rehabilitation
Phone (918) 453-5004 Fax (918) 458-4482
vocational_rehab@cherokee.org

DOCUMENT CHECKLIST

In order to complete the application process, the applicant must provide at least one form of documentation for each of the following areas indicated.

DOCUMENTS REQUIRED:

☐ **PROOF OF INCOME (Include income for all household members)**

Examples: *Social Security Award Letter, VA Award Letter, Copy of Benefit Check, Income Verification from DHS (TANF), Pay Stubs, Letter from Employer, etc.*

☐ **PROOF OF TRIBAL MEMBERSHIP**

Examples: *Tribal Membership Card from Federally Recognized Tribe, Letter from Agency (BIA), etc. (For Cherokee Citizens, please provide both blue and white cards)*

☐ **PROOF OF SOCIAL SECURITY NUMBER**

Examples: *Social Security Card*

☐ **PROOF OF PHYSICAL ADDRESS (P.O. BOX NOT ACCEPTED)**

Examples: *Utility Bill, Driver's License, Rent Receipt, etc.*

☐ **PROOF OF DISABILITY**

Examples: *Medical/Psychological Records (last 3 years), School Assessment Records (IEP)*

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APPLICATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Tel./Cell Number: _____ Alternate Number: _____

Physical Address: _____

Mailing Address: _____

County: _____ Email Address: _____

What is your disability? And when did it occur? (Month & Year)

How does your disability limit your ability to work or obtain employment?

My signature to this document constitutes an application for rehabilitation services. In order to affect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. All information, both medical and personal, given or made available to the agency shall be held confidential.

Use of such information will be limited to purposes directly connected with the administration of my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended. Failure to provide this information may prevent the rehabilitation program from providing services in a timely manner.

CONSUMER RIGHTS AND REMEDIES

I have been advised of the availability of the Client Assistance Program (CAP) and have received a brochure explaining the purpose of the CAP office. For assistance call 1-800-522-8224.

I understand that I may request an administrative review if I do not agree with a decision made by my counselor. An administrative review may be requested by contacting the Cherokee Nation Vocational Rehabilitation Program Manager verbally or in writing within 30 days of the effective date of the decision.

Consumer Signature: _____ Date: _____

Parent/Gaurdian/Rep: _____ Date: _____

Voc. Rehab. Counselor: _____ Date: _____

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Who referred you to our office? _____

Have you ever applied for or received State or Tribal Vocational Rehablitation services? ☐ Yes ☐ No

If yes, When/Where?

Do you have a ticket to work? ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, please explain: _____

Do you have charges pending? ☐ Yes ☐ No

If yes, please explain: _____

Are you a veteran? ☐ Yes ☐ No Is disability connected? ☐ Yes ☐ No

If yes, please specify: _____

Have you used any alternate names? ☐ Yes ☐ No

If yes, please specify: _____

Do you have a reliable vehicle? ☐ Yes ☐ No Number of Vehicles: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Seperated

Total number living in your home: _____

List all household members with monthly income (include those with wages, VA, SSI, SSDI, TANF, Worker's Comp, Unemployment, etc.)

Name	Relationship	Income type	Amount

Are you or any household member receiving any other tribal benefits? ☐ Yes ☐ No

If yes, please explain: _____

EDUCATION & WORK HISTORY

Have you ever been defaulted on a student loan? ☐ Yes ☐ No

If Yes, list status of student loan: _____

EDUCATION HISTORY

High School/GED

(School Name) (Grade Complete/GED Certificate) (Dates)

Technical

(School Name) (Grade/Certificate Completed) (Dates)

College/University

(School Name) (Hours Completed/Course of Study) (Dates)

EMPLOYMENT HISTORY

(List 3 most recent jobs)

(1 . Employer Name) (Job Title) (Dates MM/YY-MM/YY)

(Reason for Leaving) (Beginning Wages) (Ending Wages)

(2. Employer Name) (Job Title) (Dates MM/YY-MM/YY)

(Reason for Leaving) (Beginning Wages) (Ending Wages)

(3. Employer Name) (Job Title) (Dates MM/YY-MM/YY)

(Reason for Leaving) (Beginning Wages) (Ending Wages)

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CONSUMER RESPONSIBILITY STATEMENT

(Please read carefully)

I certify that the information I have given is true, correct, and complete to the best of my knowledge.

I understand that the Cherokee Nation Vocational Rehabilitation Program has 60 days from the date of application to find me eligible or not eligible. After careful review of my full and complete application, including the required documents, I will be notified of a decision.

I agree to notify my Rehabilitation Counselor within 30 days, if I have a change in my living arrangements, address, telephone number, income, automobiles, or resources of any kind.

I agree to notify my Rehabilitation Counselor within 30 days, if I have a change in my expenses or needs.

Upon notification of such changes, I understand my case will be reviewed and revised to reflect any new information.

I understand that the information I have given will be carefully reviewed and that I might be asked to provide proof of the answers given. Furthermore, I understand that any false statements make me subject to prosecution for fraud. I hereby authorize the Cherokee Nation Vocational Rehabilitation Program to make any necessary investigations to verify the information I have given.

I understand if I falsified any information, services through the Cherokee Nation Vocational Rehabilitation Program may be suspended. I understand that I will be notified of the Program's decision and have 5 working days to respond. If no acceptable response, explaining the circumstance, is received, services will be cancelled and all costs incurred will be my responsibilty.

I also agree to provide employment verification, to my VR counselor, once my training is complete and an employment outcome has been achieved.

_____
(Print Name)

_____ _____
(Signature) (Date)

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HEALTH INFORMATION

Do you have any of the following?	Please answer "Yes" or "No" to all		If yes, has it kept you from working?	
	Yes	No	Yes	No
1. A disorder of the eyes, ears, nose, or throat	☐	☐	☐	☐
2. Frequent dizziness, fainting, headaches, seizure, paralysis, or stroke	☐	☐	☐	☐
3. A mental or nervous disorder	☐	☐	☐	☐
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other lung disorders	☐	☐	☐	☐
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels	☐	☐	☐	☐
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver or gallbladder	☐	☐	☐	☐
7. Disorder of kidney, bladder, prostate, or reproductive system	☐	☐	☐	☐
8. Diabetes, thyroid, or other endocrine disorders	☐	☐	☐	☐
9. Arthritis, or other disorder of the muscles or bones including the spine, back , or joints	☐	☐	☐	☐
10. Absence or amputation of any body parts	☐	☐	☐	☐
11. Loss of use of arms, legs, or other body parts	☐	☐	☐	☐
12. A tumor, cancer, disorder of skin or lymph glands	☐	☐	☐	☐
13. Allergies	☐	☐	☐	☐
14. Anemia or other disorders of the blood	☐	☐	☐	☐
15. Alcohol or substance abuse	☐	☐	☐	☐
16. Any other physical or mental condition not listed				

Have you ever been or are you currently being treated for any of these conditions? ☐ Yes ☐ No

Condition	Dr. Name/Facility	Address

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ SS#: _____ DOB: _____ Record No. _____
hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

Name of Agency/Individual to Receive PHI:	***Name of Facility/Individual to Disclose PHI:***
Cherokee Nation Vocational Rehabilitation	_____
Attn: _____	_____
P.O. Box 948	_____
Tahlequah, OK 74465	_____

Portions to be released (check all that apply):

☐ Medical ☐ Psychological ☐ Other (Specify): _____

Date(s) of Services:

The information shall be obtained, used or disclosed for the **following purpose(s) only**:

☐ Establish eligibility for rehabilitation services ☐ Develop a vocational program for consumer

The information I authorize may include records which may indicate the presence of a communicable or non-communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus, also know as Acquired Immune Deficiency Syndrome (AIDS). I understand that these records may include psychiatric, alcohol and drug abuse information, occupation information, or information regarding other insurance coverage. **I specifically authorize the release of my drug, alcohol and/or mental health treatment records. The information obtained with this disclosure form is required to be kept confidential by the Cherokee Nation Vocational Rehabilitation Program under Federal Law 34CFR 361.38.**

Information used or disclosed pursuant to this authorization may by subject to re-disclosure by the recipient and no longer protected by Federal Law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements

I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by the law.

Right to revoke: I may revoke this authorization by sending a written request to the Cherokee Nation Vocational Rehabilitation Program at the address listed above. Revocation will not apply to information already used or disclosed in response to this authorization.

Termination date: This Authorization expires (12) months following the date signed.

Consumer Signature: _____ Date: _____

Parent/Gaurdian/Representative: _____ Date: _____

Cherokee Nation Substitute W-9 Form
Request For Taxpayer Identification Number and Certification

NOTE: Your United States TAXPAYER IDENTIFICATION NUMBER MUST be provided regardless of your tax status. Name must be the same as that filed with the IRS or the Social Security Administration as applicable. Failure to return this form in a timely manner will delay the order and/or payment. By Federal Law, the following information needs to be completed and returned to your procurement contact person at Cherokee Nation.

PRINT OR TYPE

LEGAL NAME
(As entered with IRS) If Sole Proprietorship, enter your LAST, FIRST, MI

TRADE NAME
If doing business as (D/B/A) or business name of Sole Proprietorship

Vendor Entity Type: (Select only one box)
- ☐ Individual/Sole
- ☐ Corporation
- ☐ Partnership
- ☐ Government
- ☐ Non-Profit
- ☐ Other
- ☐ Limited Liability Company: Enter the tax classification (D=disregarded entity, C=corporation, P=partnership)

PRIMARY ADDRESS (For return of 1099 Form)
PO Box or number and street

City, State, Zip + 4

Minority Certification: (Select all if apply)
- ☐ Other Minority (attach certificate if checked)
- ☐ Veteran
- ☐ Small (attach certificate if checked)
- ☐ Disabled Veteran
- ☐ Woman Owned (attach certificate if
- ☐ Cherokee Owned
- ☐ Small Business
- ☐ Indian Owned (Tribe): _____

ORDER ADDRESS (Where order should be sent, if different than
PO Box or number and street

City, State, Zip + 4

Contact Name:
Contact Title:
Email Address:
Phone Number:
Fax Number:

REMIT ADDRESS (Where check should be sent, if different than above)
PO Box or number and street

City, State, Zip + 4

Contact Name:
Contact Title:
Email Address:
Phone Number:
Fax Number:

TAXPAYER IDENTIFICATION NUMBER (TIN) (Provide One Only)
If sole proprietorship provide SSN & FEIN if applicable

Social Security Number (SSN) _____

OR

Federal Employer Identification No. (FEIN) _____

NAICS/SIC Industry Code
Code: _____

Industry Title: _____

WHAT WILL YOU BE PROVIDING?
- ☐ Goods
- ☐ Services
- ☐ Both

Does any owner, sales/service representative, or employee, have a personal relationship with a CN employee (includes all tribal locations)?
- ☐ Yes (if yes, please attach a letter of explanation)
- ☐ No

Has your firm and/or is your firm involved in Federal debarment process?
- ☐ Yes (if yes, please attach a letter of explanation)
- ☐ No

FOR CN USE ONLY

1099 ☐ Yes ☐ No

VEND ☐ Addition ☐ Change

CERTIFICATION: Under penalties of perjury, I declare that the information I provided is correct and complete

Signature _____ Phone (____) _____

Title _____ Date _____

Please Print

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