ICAS

INUPIAT COMMUNITY OF THE ARCTIC SLOPE

Tribal Vocational Rehabilitation
4772 Ahkovak Street, PO Box 934,
Barrow-Utqiagvik AK 99723
Phone: (907) 852-4227

APPLICATION FOR TRIBAL REHABILITATION SERVICES

All information provided is confidential and is used for eligibility determination and possible services.

Name: _____

Name you wished to be called: _____

Home Address: _____

Mailing Address: _____

SS#: _____ Birth Date: _____

Martial Status: Married Single Divorced Widowed Significant Other

Home Phone: _____ Cell: _____ Message Phone: _____

Email Address: _____

Name 2 people not living with you who will know your address or phone number:

_____ Phone: _____
(Name) (Relationship)

_____ Phone: _____
(Name) (Relationship)

My disabilities are: _____

I am requesting the following types of services: _____

What type of employment would you like? _____

Who referred you to Tribal Vocational Rehabilitation? _____

Have you been a TVR client? Yes____ No____ Have you been a DVR client? Yes____ No____

Circle the programs you want: I am requesting services from: Tribal VR State DVR Both Programs

*This Application contains pages from the State DVR application that is information we need to have. Should you decide you want State DVR or Both Programs the information in this application will not need to be duplicated and it will be used as part of the State DVR application and sent to them with your authorization.

Applicant Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Counselor's Signature: _____ Date received: _____

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Client Rights & Responsibilities & Disclosure

- To participate fully in the development of your own Individual Plan of Employment (IPE)
- To be treated with dignity and to treat others with dignity.
- To have your eligibility for services determined within 60 days of receipt of application, unless there are circumstances that require an extended amount of time.
- To have a fair and complete evaluation to determine eligibility that you will assist with as needed.
- To have degreed and trained Vocational Rehabilitation Counselors/Staff or to be supervised by one & learn what those degrees and trainings have been.
- To have your records and communication kept confidential. Information will not be released without your authorization, unless under court order.
- To make informed choices during your Vocational Rehabilitation experience.
- To be provided information about the Client Assistance Program (CAP) for problem resolution.
- To access and receive services in a reasonably barrier free environment, including communication in an alternate format as needed.
- To reasonably receive appropriate Assistive Technology for assessment or services leading to a job.

- If the Vocational Rehabilitation Counselor has knowledge that you are going to harm yourself or others, he/she is required to notify the proper authorities or officials.
- If the Vocational Rehabilitation Counselor believes you are going to harm or endanger or abuse children or the elderly, he/she will report this to state or local authorities.
- If you are a minor or not your own legal guardian, then the information in your file may be available to your legal guardian or advocate.

- To take an active role in the development & implementation of your Individual Plan or Employment.
- To request disability related accommodation's you may require.
- You are to apply for and secure funding for which you may be eligible such as financial aid, insurance, Veterans benefits, and any fees or billing arrangements.
- To actively participate and maintain regular contact with the Vocational Rehabilitation Program.
- To talk to the VR Counselor if you are having a problem that is affecting your IPE.
- To actively seek and gain employment.

I have reviewed this page. The Vocational Rehabilitation counselor has answered all questions I have about my rights, responsibilities, and disclosures, though I know I may ask questions about them at any time I am receiving services. I have received my own copy of this form.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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Grievance Process

Tribal Vocational Rehabilitation staff are committed to providing professional quality assistance and support for individuals with disabilities. If, as an applicant or participant with TVR, you do not agree with a decision or action taken by TVR, you have the right to appeal. First, try to resolve problems with your counselor or program manager. They may be willing to consider another option and will give you valid reasons if alternatives are not appropriate. Most disagreements can be resolved at this level.

YOU CAN

- Discuss the situation with your counselor, or TVR Program Manager.
- Call the Client Assistance Program (CAP), an advocacy service independent of TVR for assistance. (800) 966-0047 Fairbanks or (800) 418-0047 Anchorage, Alaska.
- Ask for an Administrative Review, Mediation, and a Fair Hearing.

CLIENT ASSISTANCE PROGRAM

You may request assistance From the CAP (Client Assistance Program) to help resolve programs or misunderstanding with your counseling team that may occur during your Rehabilitation program. CAP is independent of ICAS VR and provides advocacy and information free of charge. Your counselor will give you a brochure with additional information about CAP.

THE APPEAL PROCESS

If you are unable to resolve programs through the assistance of your TVR Counselor or TVR Program Manager and CAP, you have the right to request an Administrative Review, Mediation, or a more formal hearing before an impartial hearing officer. You must start the appeal process in writing within 30 days of the decision or action with which you disagree.

ADMINISTRATIVE REVIEW

An administrative review is an informal meeting with the TVR Counselor or TVR Program Manager. This individual will attempt to resolve the issue to your satisfaction. You must request the review in writing and:

1. Include the date of this decision or action you want to have reviewed.
2. Describe the decision or action you need to have resolved
3. Include your name, address and telephone number, and if appropriate, that of your representative.
4. Sign and mail to: Program Manager PO BOX 934 Utqiagvik, AK 99723.

MEDIATION

Mediation is an alternative dispute resolution process where a trained impartial mediator attempts to help both parties seek an agreement to their differences. Your request for mediation must be made to the Program Manager of ICAS, TVR. Mediation is voluntary on the part of both parties.

FAIR HEARING

A Fair Hearing is a formal review process, Legal fees are not paid by TVR, but you may obtain assistance to prepare for this hearing through CAP. You will present your disagreement to a review board consisting with at least 3 of the following ICAS TVR, Program Manager; ICAS Executive Director, representative from State DVR, representative from another tribal VR program within Alaska, another consumer of TVR services. The review board will hear your disagreement in person or via teleconference within 15 working days of your request. To request a Fair Hearing, submit a written request to ICAS TVR Program Manager including the date of the decision or action you want to have reviewed, a description of the decision or action you want to have resolved, your name, address, and telephone number (and if appropriate, that of your resolved, your name, address, and telephone number) and if appropriate that of your representative. *Sign and mail the request to the TVR Program Manager.* ICAS P.O. Box 934 Utqiagvik, AK 99723.

I have reviewed the above Grievance Procedure. My Tribal Vocational Rehabilitation Counselor has answered all questions I have about these procedures; though I know I may ask questions about my rights or responsibilities at any time while receiving services. I have received my own copy of this form.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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ICAS Vocational Rehabilitation Program

Involuntary Discharge and Termination from Program Criteria

Client may be discharged from the program for any of the following reasons:

1. Any threats, intimidation or act of violence directed towards staff members or other clients.

2. Bringing drugs, alcohol or weapons on premises.

3. Three unexcused absences from regularly scheduled appointments, including substance abuse, mental or physical health or others as documented in IPE.

4. Attempts to steal from and/or cause the loss of program property belonging to staff or other clients.

5. Conviction and incarceration for crimes that place clients outside boundaries for a period in excess of one year.

6. A determination by program staff that the client is not amenable to rehabilitation: e.g. client fails to participate or lacks the ability to participate.

7. Giving false or misleading statements, information and documentation

8. Violating a Client Contract/Agreement.

I have read the above and agree to the conditions numerated and voluntarily consent to the conditions and treatment.

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

Staff Signature Date: _____ Date: _____

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Limited Release of Information

Inupiat Community of the Arctic Slope
Tribal Vocational Rehabilitation Program

Client Name: _____

Client Address: _____

The information is to be released To and/or From:

Name of Facility/Person/Organization: _____**Auditors**_____

Address: _____**C/O ICAS Vocational Rehabilitation**_____

City/State/Zip Code: ___**PO Box 934__Utqiagvik, AK 99723**_____

Tel: _**907-852-4227**_____ Fax: _____

AUTHORIZATION

I authorize ICAS Vocational Rehabilitation Program to share only the minimal required information with the auditors that shows them the ICAS Program has provided eligibility for me with the appropriate documentation as required to complete the audit.

I understand that I may cancel this authority at any time, except to the except to the extent that action has already been taken. Unless cancelled earlier by me, this authorization will expire one year from the signature date or on the specified expiration date.

Expiration Date: _____

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

ICAS
INUPIAT COMMUNITY OF THE ARCTIC SLOPE

Tribal Vocational Rehabilitation
4772 Ahkovak Street, PO Box 934,
Barrow-Utqiagvik AK 99723
Phone: (907) 852-4227

Release for Print and Photographs

I, _____ authorize the ICAS Vocational Rehabilitation Program to use general information about my association with their program as a Vocational Rehabilitation Client and pictures of me to include us in:

In-Print or On-Line Newsletters, Newspaper Articles, Flyers, Tribal Web Sites, Posters, or Brochures, as well as in TV programming.

This authorization will be valid until such time I inform the ICAS Vocational Rehabilitation Program I no longer want them to use information or pictures in print, on-line, or in other forms of communications.

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

Staff Signature Date: _____ Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____ (*Name of Patient*), hereby voluntarily authorize the disclosure of information from my health record.

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY Sammual Simmonds Memorial Hospital	NAME OF PERSON/ORGANIZATION/FACILITY ICAS Vocational Rehabiliation Program
ADDRESS PO Box 1232/7000 Uula Street	ADDRESS PO Box 934/4772 Herman St
CITY/STATE Barrow, Alaska 99723	CITY/STATE Barrow, AK 99723

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)* _____
☐ Personal Use ☒ Disability ☐ Research ☒ Health Information Exchange *(IHS/Other)* Voc Rehab Services

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☒ Only the period of events from Complete Summary to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date (mm/dd/yyyy) or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

PSC Publishing Services (301) 443-6740 EF

ALASKA NATIVE MEDICAL CENTER
4315 Diplomacy Dr. Anchorage, AK 99508
Email: akahimroiteam@anthc.org Phone: 907-729-3019 Fax: 907-729-3001

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT

Name: _____ **Birth Date:** ____/____/____

Other Names Used: _____

FROM

I request patient's information be sent by:

■ Alaska Native Medical Center (Alaska Native Tribal Health Consortium & Southcentral Foundation)

☐ Another health care provider name here: _____

PROVIDE TO

Who do you want the patient information to be sent to?

Name: ICAS Vocational Rehabilitation **Phone Number:** 907-853-4227

How do you want the medical information to be sent?

☐ It will be picked up.

■ Mail to this address: PO Box 934 Barrow AK 99723

☐ Fax to: _____ *

☐ Email to: _____ *

☐ Other (describe): _____

*Sending information by Fax or Email increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber attack.

Record Format: ☐ Paper ☐ Disc ☐ Other: _____ *Note:* If no selection is marked, paper records are mailed.

REQUESTED INFORMATION

Please check or describe the health information that you would like disclosed:

☐ Consultations	☐ Discharge Summaries	☐ History & Physical Exams
☐ Medications Records	☐ Physician Reports	☐ Nursing Notes
☐ Laboratory Results	☐ Pathology Reports	☐ Radiology & Imaging Reports
☐ Immunization Record	☐ EKG Reports	☐ Emergency Dept. Records
■ Complete Record	☐ Sleep Study	☐ School Physical

☐ Records for the following dates or treatment: _____

☐ Other: _____

Specific Sensitive Information needs to be initialed to be disclosed:

___Mental/Behavioral Health Treatment ___Drug/Alcohol Abuse ___HIV/AIDS Information ___STD Treatment

PURPOSE

Why are you requesting this disclosure?

☐ Personal Use ☐ Legal ☐ State/Federal ☐ Insurance/Benefits ☐ Care Coordination ☐ School ■ Other: Disability

VALIDITY

Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ___/___/___ **Revocation:** An authorization may be revoked at any time by written notice to ANMC Health Information Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

PATIENT RIGHTS

I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse sign this authorization - ANMC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by ANMC by contacting Health Information Management. I may be charged a reasonable fee for copying costs.

REQUESTOR

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

Signature: _____ **Date:** ____/____/____

Print Name: _____

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: _____

Mailing Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

How should we contact you if there are questions? ☐ Phone: _____ ☐ Email: _____

OFFICE USE ONLY: MRN #: _____ Verification Method: _____ ☐ Priority or ☐ Archive

Sent by: ☐ PU ☐ Mail ☐ Fax ☐ Email ☐ Other: _____ Date Sent: ____/____/____ Staff Initials: _____

NORTH SLOPE BOROUGH | Department of Health & Social Services
Integrated Behavioral Health
P.O. Box 69 | Barrow, Alaska 99723
Phone: (907) 852-0366 | Fax: (907) 852-0268

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Patient D.O.B _____

Address _____ City/State _____ Zip _____ Phone Number _____

I, _____, hereby authorize the North Slope Borough Health Department to:
(Name of Patient/Authorized Representative)

- ☒ DISCLOSE information TO & OBTAIN information FROM
- ☐ ONLY OBTAIN information FROM (check if limiting information direction)
- ☐ ONLY DISCLOSE information TO (check if limiting information direction)

Organization/Name: ICAS Vocational Rehabilitation
Mailing Address: PO Box 934
City, State, Zip: Utqiagvik, AK, 99723
Phone: 907-852-4227 Fax: _____

The purpose and need of this disclosure is (check all that apply):

☐ Further Medical Care ☐ Legal ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☑ Disability ☐ Other (specify): _____

Initial each category you want disclosed:

_____Medical
_____Alcohol/Drug Abuse Treatment/Referral
_____Mental Health (except Psychotherapy Notes)
_____HIV/AIDS-Related Treatment
_____Sexually Transmitted Diseases

Initial each category you want disclosed:

_____Entire Record
_____Only Information Related To (specify): _____
_____Only Information Between The Period Of:
(date): _____ and (date): _____

I understand that I may revoke this authorization, in writing, submitted at any time to the Health & Social Services Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date.

Expiration date: _____

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

I understand that the Health & Social Services Department will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

_____ _____
Signature of Patient Date

_____ _____
Signature of Authorized Representative (State Relationship to Patient) or Witness (If Signature is Thumbprint or Mark) Date

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Barrow-Utqiagvik AK 99723
Phone: (907) 852-8156

Client Consent to Release Information To ICAS

Inupiat Community of the Arctic Slope
Tribal Vocational Rehabilitation Program

Client Name: _____ SSN: ____-____-____ DOB: _____

Client Address: _____

The information is to be released from:

Name of Facility/Person/Organization: _____

Address: _____

City/State/Zip Code: _____

Tel: _____ Fax: _____

Email: _____

AUTHORIZATION

I authorize the mutual exchange of information in person, by telephone, fax, or email, regarding myself between the above indicated parties for the express purpose of: Obtaining records that will document a disabling condition for use in determination of eligibility for services through the Inupiat Community of the Arctic Slope Vocational Rehabilitation Program, and for exchange medical/education/therapeutic/social/economic/family/legal and all other Information for service plan development and ongoing Tribal Vocational Rehabilitation Services. I have been offered a copy of this document.

Other or specific Information (Specify):

_____

_____

_____

I understand that I may cancel this authority at any time, except to the except to the extent that action has already been taken. Unless cancelled earlier by me, this authorization will expire one year from the signature date or on the specified expiration date.

Expiration Date: _____

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

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Client Consent to Release Information To ICAS

Inupiat Community of the Arctic Slope
Tribal Vocational Rehabilitation Program

Client Name: _____ SSN: ____-____-____ DOB: _____

Client Address: _____

The information is to be released from:

Name of Facility/Person/Organization: _____

Address: _____

City/State/Zip Code: _____

Tel: _____ Fax: _____

Email: _____

AUTHORIZATION

I authorize the mutual exchange of information in person, by telephone, fax, or email, regarding myself between the above indicated parties for the express purpose of: Obtaining records that will document a disabling condition for use in determination of eligibility for services through the Inupiat Community of the Arctic Slope Vocational Rehabilitation Program, and for exchange medical/education/therapeutic/social/economic/family/legal and all other Information for service plan development and ongoing Tribal Vocational Rehabilitation Services. I have been offered a copy of this document.

Other or specific Information (Specify):

_____

_____

_____

I understand that I may cancel this authority at any time, except to the except to the extent that action has already been taken. Unless cancelled earlier by me, this authorization will expire one year from the signature date or on the specified expiration date.

Expiration Date: _____

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Vocational Rehabilitation
A proud partner of the American Job Center Network

STATE OF ALASKA
DIVISION OF VOCATIONAL REHABILITATION (DVR)
AUTHORIZATION TO RELEASE PERSONAL/CONFIDENTIAL/SENSITIVE INFORMATION

★ **Required information. These sections must be filled in.**

★ **From** :

Participant's Printed Name _____ Date of Birth _____ SSN=XXX-XX- _____
SSN **if needed** (use only last 4 digits)

(Participant is to initial in the box of the release type(s) required.)

★ ☐ I grant permission for you to release to the Alaska Division of Vocational Rehabilitation the following information:

☐ I grant permission for the Alaska Division of Vocational Rehabilitation to release to you the following information:

★ **To:** _____ _____
Organization's/Individual's Name Other Identifying Information (address, phone #, title, etc.)

★ **For the Specific Purpose of:** Determining Eligibility and Identifying Vocational Rehabilitation Services
(Determining Program Eligibility or Identifying VR Services)

PART I

(Participant is to initial in the box of the record type(s) required.)

Medical

☐ Medical Records
☐ Hospital Records

Psychiatric/Psychological

☐ Psychiatric Reports/ Evaluations
☐ Neuropsychological/ Psychological Testing

Academic

☐ School Transcripts/Grade Reports
☐ IEP/Special Education Reports

Corrections

☐ Corrections/Arrest Records
☐ Furlough/Parole/ Probation Stipulations

Other Types of Information

☐ (Specify) _____
☐ (Specify) _____

Mail/ email to:
SOA DOLWD DVR - VRC Kim Nesbitt
455 3rd Avenue, Suite 150
Fairbanks, AK 99701
kimberly.nesbitt@alaska.gov
(907) 451-3104

Fax to: (907) 451-3093

Information pertaining to: Diagnosis/Prognosis/Treatment Recommendations/Functional Limitations 2016-Present
(Specify dates of treatment, medical condition(s), etc.)

PART II

Drug & Alcohol or Sensitive Information (HIV/STD status-genetic testing-DV or sexual abuse)

(Participant is to initial in the box of the record type(s) required.)

☐ Drug & Alcohol Treatment Records
☐ Discharge Summary W/Treatment Dates
☐ Assessment Results & Recommendations
☐ Domestic Violence/Sexual Abuse
☐ HIV/AIDS /STD status
☐ (Specify) _____

PROHIBITION ON REDISCLOSURE: Information requested in Part II has been disclosed from records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting any further disclosure except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. *The confidentiality of all information requested with this authorization is protected by AS 23.15.190 and 34 CFR 361.38. This authorization of release also complies with 45 CFR 164.508.*

Note: This consent is subject to revocation at any time, except to the extent that the program that is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will automatically expire upon DVR exit date OR on: _____
Expiration Date

★ _____ Participant's Signature _____ Date _____ *Parent/Guardian/Conservator Signature _____ Date

_____ ** Witness' Signature _____ Date _____ ** Witness' Signature _____ Date

*** If a participant is a minor, signature of a parent or guardian is required.**
**** If unable to write his or her name, the participant should enter an "X" or other mark. Signatures of two witnesses are required.**

Alaska Division of Vocational Rehabilitation

Participant Information Questionnaire

Revised July 2017

Name *Last* *First* *Middle* *Preferred Name*

Primary Phone *Check one:* ☐ Cell ☐ Landline ☐ VP

Is this your phone? ☐ Yes ☐ No If no, name/relationship:

Part I General Information

Have you ever applied for vocational rehabilitation services before? ☐ Yes ☐ No

If yes, where? **When?**

Do you want to register to vote? ☐ Yes ☐ No ☐ No, I am already registered to vote ☐ Not eligible

(Under the National Voter Registration Act, DVR is considered a voter registration agency and is required to offer you the opportunity to register to vote. If a Voter Registration Rights and Declination Form has not already been provided to you, please notify a staff person.)

Race - Please mark all that apply: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American or Black ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian / White

Ethnicity (mark in addition to race) ☐ N/A ☐ Hispanic or Latino *(i.e., Cuban, Mexican, Puerto Rican, South or Central America.*

What is your primary language?

English Speaking Ability ☐ Functional ☐ Limited

English Reading Ability ☐ Functional ☐ Limited

What is your preferred method of communication? ☐ Text Msg. ☐ Email ☐ Mail ☐ VP ☐ Phone Call

Do you have any additional considerations, such as language interpreters or environmental concerns that require accommodation?

Are you a Veteran of the US Armed Forces? ☐ Yes ☐ No

Have you registered for the Selective Service? ☐ Yes ☐ No If yes, Selective service #

Living Arrangement

☐ Adult Correctional Facility ☐ Homeless Shelter ☐ Private Residence
☐ Community Residential / Group Home ☐ Mental Health Facility ☐ Rehabilitation Facility
☐ Halfway House ☐ Nursing Home ☐ Substance Abuse Treatment Facility
☐ Other If other, specify where:

Marital Status ☐ Married ☐ Single ☐ Domestic Partnership

United States Citizen? ☐ Yes ☐ No **If no, legal status to work in the U.S.?** ☐ Yes ☐ No

How did you find out about Vocational Rehabilitation? **(Mark only one)**

- ☐ Adult Education and Literacy Program *(ABE, ESL)*
- ☐ Centers for Independent Living *(Access AK)*
- ☐ Child Protective Services *(OCS)*
- ☐ Consumer Organizations or Advocacy Group
- ☐ DOL Employment and Training *(Job Corps, CSTS)*
- ☐ Educational Institution *(high school)*
- ☐ Educational Institution *(college/vocational)*
- ☐ Employer
- ☐ Extended Employment
- ☐ Faith Based Organization
- ☐ Family/Friends
- ☐ Intellectual & Developmental Disabilities Provider
- ☐ Job Center Wagner-Peyser Employment Services
- ☐ Medical Health Provider *(public or private)*
- ☐ Mental Health Provider *(public or private)*
- ☐ Public Housing Authority *(AHFC, CIHA, HUD)*
- ☐ Self-Referral
- ☐ Social Security Administration *(DDS, TTW, District Office)*
- ☐ State Department of Corrections/Juvenile Justice
- ☐ Sub-minimum wage employer *(FLSA 14c)*
- ☐ TANF
- ☐ Tribal Voc. Rehab. *(AIVRS,CITC,APIA,ICAS)*
- ☐ Veterans Benefits Administration *(includes VR&E)*
- ☐ Veterans Health Administration
- ☐ Vocational Community Rehabilitation Program
- ☐ Welfare Agency *(Public Assistance)*
- ☐ Workers' Compensation
- ☐ Other One-Stop Partner
- ☐ Other Sources:
- ☐ Other State Agencies
- ☐ Out of State VR State Agencies
- ☐ Other WIOA-funded Programs *(MASST, WIOA Youth)*

Part II Income and Household Information

# in Household	# of Dependents	Household Income(Monthly): *(includes earning & personal income for all family members over 18 years old who live in household)*

What is your primary source of support? *(Select only one)*

- ☐ Personal Income *(Earnings, interest, dividends, rents, retirement, Social Security retirement, alimony, child support)*
- ☐ Family and Friends
- ☐ Public Support *(SSI, SSDI, TANF/ATAP, Workers' Comp Unemployment Insurance, Food Stamps, rent subsidies)*
- ☐ Other sources of support *(Private disability, private charities)*

Indicate your Social Security benefit status

SSDI

- ☐ Applicant - Allowed Benefits
- ☐ Applied – Denied Benefits
- ☐ Applicant – Status Pending
- ☐ Benefits – Allowed Due to Survivorship
- ☐ Benefits Discontinued or Terminated
- ☐ Unknown
- ☐ Not an Applicant

SSI – Aged / Blind / Disabled

- ☐ Applicant - Allowed Benefits
- ☐ Applied - Denied Benefits
- ☐ Applicant - Status Pending
- ☐ Benefits – Allowed Due to Survivorship
- ☐ Benefits Discontinued or Terminated
- ☐ Unknown
- ☐ Not an Applicant

Do you have a Ticket to Work? ☐ Yes ☐ No ☐ Don't know

If you are receiving any of the following, please indicate the monthly amount you are receiving:

Type of Support	Amount	Type of Support	Amount
SSI, Aged	$	ATAP/TANF	$
SSI, Blind	$	APA/General Assistance	$
SSI, Disabled	$	Workers' Compensation	$
SSDI, Disabled	$	Unemployment Insurance	$
SSDI, Other	$	Other (Tribal)	$
Veterans	$		

Check any of the following health insurance or coverage you have available: ***(Mark all that apply)***

- ☐ Medicare
- ☐ Medicaid/Denali Kid Care
- ☐ Public insurance from other sources *(Indian Health Services & VA)*
- ☐ State or Federal Affordable Care Act Exchange
- ☐ Private insurance through own employer
- ☐ Private insurance through spouse or family
- ☐ Private insurance through own employer pending
- ☐ None

Part III Employment Information

What was the last date you worked? _____

Are you requesting services to maintain employment? ☐ **Yes** ☐ **No**

Were you employed or not this past week? Check which box applies.

- ☐ Competitive Integrated Employment
- ☐ Employed-Received Notice of termination
- ☐ Self Employed *(Except state sponsored Business Enterprise Program)*
- ☐ BEP *(State sponsored Business Enterprise Program)*
- ☐ Competitive Integrated Employment with supports
- ☐ Employed-Transitioning Military Service Member
- ☐ Not Working – Student in Secondary Education
- ☐ Not Working – All Other Students
- ☐ Not Working – Trainee, Intern or Volunteer
- ☐ Not Working

Hours worked per week: _____

Salary $ _____ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Part IV Work History, Last 10 Years or Last job worked if more than 10 years ago

Employer _____

Address _____ City _____ State _____ Zip _____

Job Title *(required)* _____

Duties _____

Reason for leaving _____

Start Date _____ End Date _____ Hours worked per week: _____

Salary $ _____ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Part IV Work History (continued)

Employer

Address City State Zip

Job Title *(required)*

Duties

Reason for leaving

Start Date End Date Hours worked per week:

Salary $ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Employer

Address City State Zip

Job Title *(required)*

Duties

Reason for leaving

Start Date End Date Hours worked per week:

Salary $ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Employer

Address City State Zip

Job Title *(required)*

Duties

Reason for leaving

Start Date End Date Hours worked per week:

Salary $ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Employer

Address City State Zip

Job Title *(required)*

Duties

Reason for leaving

Start Date End Date Hours worked per week:

Salary $ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Employer

Address City State Zip

Job Title *(required)*

Duties

Reason for leaving

Start Date End Date Hours worked per week:

Salary $ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Employer

Address City State Zip

Job Title *(required)*

Duties

Reason for leaving

Start Date End Date Hours worked per week:

Salary $ Check One: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Part V Contact Information

Whom can we contact if we are unable to reach you directly?

Contact Person Relationship

Phone *Check one:* ☐ Cell ☐ Landline ☐ VP Email

Part VI Education Information

High School Education

☐ **I did not complete high school.** The last grade I completed was: grade. Date completed:

☐ **I'm in high school now.** Name of high school:

The last grade I completed was: Date completed (MM/YYYY):

I have an IEP: ☐ **I have a 504:** ☐

☐ **I graduated from high school.** Graduation Date (*MM/YYYY*): ☐ With a high school diploma.

OR

I received a: ☐ **GED** Date completed:

☐ **Certificate of Attendance** Date completed:

College Education

☐ **I have not taken any college credits.**

☐ **I'm currently enrolled or I have taken some college courses but have not received a degree.**

The last course I completed was: _____ Date completed: _____

☐ **I have a college degree.**

I received:

☐ **Associate's** Date completed: _____ ☐ **Bachelor's** Date completed: _____

☐ **Master's** Date completed: _____ ☐ **Doctorate** Date completed: _____

Vocational Training and Technical License or Certificates

Please list the names of any additional licenses or certificates you have received, and list if you have attended any job training programs. (Examples of licenses and certifications: Licensed Hairdresser, HVAC Tech, Vet Tech. Examples of job training programs: Job Corps, Apprenticeships, Vocational Schools, or Military)

Name of Program or School	Type of Credential	Date Completed
	☐ License (Name): ☐ Certification (Name): ☐ Other (Please describe):	
	☐ License (Name): ☐ Certification (Name): ☐ Other (Please describe):	
	☐ License (Name): ☐ Certification (Name): ☐ Other (Please describe):	

Part VII Other Agencies Involved With (Select as many as applicable)

☐ Adult Employment & Training *(CSTS)*
☐ Adult Education
☐ Dislocated Worker
☐ Job Corps
☐ Veterans Benefits Administration *(VR&E)*
☐ Job Center (Wagner-Peyser Employment Services)
☐ Youth Services
☐ Tribal Vocational Rehabilitation *(AIVRS,CITC,APIA,ICAS)*

Part VIII Difficulties with Employment

The following conditions have kept me from working or caused me difficulty with maintaining employment:

1. **I want help because I have the following disabilities that create barriers to employment:** _____

2. **I have records from the following places that explain my disabilities:** _____

3. **Related to my disability, I have difficulty with:** *(Please explain)*

- ☐ Standing
- ☐ Sitting
- ☐ Lifting
- ☐ Bending
- ☐ Typing
- ☐ Communicating
- ☐ Seeing
- ☐ Hearing
- ☐ Reading
- ☐ Writing
- ☐ Understanding
- ☐ Controlling Emotions
- ☐ Concentrating
- ☐ Handling Stress
- ☐ Making Decisions
- ☐ Remembering
- ☐ Controlling Fear
- ☐ Learning
- ☐ Getting Along with People
- ☐ Controlling Alcohol/Other Drugs
- ☐ Other

4. **Things that I have indicated above have made it hard for me to work in these ways:**

5. **To help with the difficulties mentioned in # 4, DVR could provide:**

6. **Are any of the above the result of a work-related injury?** ☐ Yes ☐ No
   If yes, are you currently involved in a Workers' Compensation case? ☐ Yes ☐ No ☐ Pending

   If yes, date of accident Employer
   Insurance adjustor Phone

7. **Describe any type of treatment you are currently receiving:**

8. **Are you able to travel unassisted?** ☐ Yes ☐ No

9. Are you receiving personal care attendant services? ☐ Yes ☐ No If yes, # hours/day

Have you been primarily employed as a Migrant or Seasonal Farmworker (food processing) for 12 consecutive months during the past two years? ☐ Yes ☐ No

Does the distance to workplace as a seasonal farmworker allow you to return to home every day? ☐ Yes ☐ No

Are you a dependent of a Migrant or Seasonal Farmworker? ☐ Yes ☐ No

Part IX Additional Barriers to Employment

- ☐ I have been unemployed for more than 27 consecutive weeks (more than 6 months).
- ☐ I am or was a foster child. (Only answer if you are 24 or younger)
- ☐ I have cultural barriers that could impact my employment.
- ☐ I am a single parent of a dependent child under the age of 18.
- ☐ I am homeless.
- ☐ I was providing unpaid services to family members.
- ☐ I have two years or less of TANF eligibility left.
- ☐ I have never had TANF or I have exhausted my TANF benefits.

Part X Legal Information

Do you have a valid driver's license? ☐ Yes ☐ No State DL#

Do you have your own transportation? ☐ Yes ☐ No

Can you provide registration and proof of insurance? ☐ Yes ☐ No

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

If yes, please explain. *(Include dates and locations)*

- ☐ Convicted of Felony: Federal
- ☐ Convicted of Felony: State
- ☐ Convicted of Misdemeanor
- ☐ Convicted Sex Offender

Are you currently on probation or parole? ☐ Yes ☐ No

If yes, please provide the following:

Probation/Parole Officer's Name

Office Address Phone

E-mail Address

Are there restrictions on the type of work you can do because of a conviction, probation, parole or other legal issues, such as child support arrears, that we need to address in your return-to-work planning? ☐ Yes ☐ No

If yes please explain

AGENCY VOTER REGISTRATION RIGHTS AND DECLINATION

_____
(Applicant's Name)

REGISTERING TO VOTE:

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

_____ YES

_____ NO

_____ No, I am already registered.

IF YOU DO NOT CHECK ONE OF THE BOXES ABOVE, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

_____ _____
Applicant's Signature Date

If you register to vote or decline to register to vote, this decision and any information regarding the office to which the application was submitted remains confidential and is used only for voter registration purposes.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may complete the application form in private, if you desire.

If you complete a voter registration application form, it will be forwarded to the state division of elections, who will assign you to a district and precinct. A confirmation card with this information will be mailed to you. **IF YOU DO NOT RECEIVE SUCH NOTICE WITHIN FOUR to SIX (4-6) WEEKS, PLEASE CONTACT THE STATE DIVISION OF ELECTIONS, (907) 465-4611.**

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register, or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint by writing or calling the Division of Elections, PO Box 110017, Juneau, AK 99811-0011, phone (907) 465-4611.

Please note that AS 15.15.010(4) and 15.07.070(d) requires that in order to be eligible to vote in an election, your registration must be received 30 days prior to any election. If your application is received after the 30-day cutoff, you will not be eligible to vote until the next election.

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