

## IOWA TRIBE VOCATIONAL REHABILITATION PROJECT

### APPLICATION PROCESS:

ANY WORKER STARTING AN APPLICATION WILL BE RESPONSIBLE FOR COMPLETION OF THAT APPLICATION.

### DOCUMENTS REQUIRED:

1. \_\_\_ PROOF OF INCOME (include income for all family members)
  - A. Social Security Award Letter or VA Award Letter
  - B. Copy of Benefit Check(s)
  - C. Income Verification from the Department of Human Services
  - D. Wages:
    1. Letter of Employer
      - a. Must be on letterhead stationary or notarized
      - b. Must include dates of employment and total gross wages for the month
    2. Copy of check stubs
  - E. Notarized Statement
2. \_\_\_ PROOF OF INDIAN DESCENT
  - A. CDIB Card
  - B. Census Card or Letter of Agency
3. \_\_\_ PROOF OF SOCIAL SECURITY NUMBER
  - A. Social Security Card
  - B. Driver's License
4. \_\_\_ PROOF OF MAILING ADDRESS/RESIDENTIAL VERIFICATION
  - A. Utility Bill
  - B. Driver's License
  - C. Rent Receipt
  - D. Voter's Registration Card
5. \_\_\_ PROOF OF DISABILITY
  - A. Doctor's Statement (dated within 1 year of application date and Disability) and/or School Assessment Records
  - B. Copy of Social Security Disability check, Aid to Disabled check, VA Disability Check.
  - C. Copy of SSI Check if applicant is less than the age of 65
6. \_\_\_ COPIES OF: \_\_\_ FASFA (PELL GRANT), \_\_\_ TRIBAL AWARD LETTER  
\_\_\_ All SCHOLARSHIPS

*Iowa Tribe of Oklahoma Vocational Rehabilitation Project  
Att: Rose Malone, Coordinator  
R.R. 1 Box 728  
Perkins, Oklahoma 74059*



EDUCATIONAL HISTORY:

	Name	City	Grade/Hrs. Completed	Major	Date
High School	_____				
College	_____				
Technical	_____				
Other	_____				

List Three People who will always know how to locate you:

Name	Address	Telephone	Relationship
_____			
_____			
_____			

Are you willing to move if employment is in another city?

What is your disability and when did it occur?

How does your disability keep you from working?

How can the Iowa Tribe Vocational Rehabilitation Services be of assistance to you?

## APPENDIX A. REHABILITATION SERVICES APPLICATION

My signature to this document constitutes an application for ITOVR services. In order to effect 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 by Rehabilitation Amendments of 1992, Title 56.

Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Information will not be disclosed to any individual agency or organization without my written consent or that of my parent, guardian, or representative as applicable.

### CLIENTS 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 CAP and the procedures for using CAP. I or my representative may call the CAP office for assistance at 1- 800-522-8224

I understand that I may request an informal administrative review or a formal appeal if I do not agree with a decision made by my counselor regarding furnishing or denial of Vocational Rehabilitation Services. A formal appeal may be requested by contacting the Director of the Iowa Tribe of Vocational Rehabilitation program RR 1 Box 721, Perkins, OK 74059

Client \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian/Rep. \_\_\_\_\_ Date \_\_\_\_\_  
(If Required)

Counselor \_\_\_\_\_ Date \_\_\_\_\_

APPENDIX B. AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, SS# \_\_\_\_\_ DOB \_\_\_\_\_  
(Client's Name)

authorize \_\_\_\_\_ Record# \_\_\_\_\_  
(doctor, hospital, clinic, or school)

or it's Director, designee or records department, to release information contained in my records to the individual or organization below:

1. Name of title of person's or organization to which disclosure is to be made:

Iowa Tribe of Oklahoma Vocational Rehabilitation Program

P.O. Box 728, Perkins, Ok 74059

Ph. 1-888-336-4692 or 405-547-547-5721

Fax Number: 405-547-1090

2. Specific type of information to be disclosed.

3.  Medical  Psychological  Vocational  Other \_\_\_\_\_

4. The purpose and need for such disclosure

Established eligibility for rehabilitation services

Develop a vocational program for client

Determine need for and/or type of treatment

Other (specify) \_\_\_\_\_

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION THAT COULD BE CONSIDERED INFORMATION ABOUT COMMUNICABLE OR VENERAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). NOTICE: INFORMATION IN YOUR RECORDS THAT YOU MAY CONFIDENTIAL BY LAW AND CANNOT BE RELEASE WITHOUT YOUR PERMMISION EXCEPT IN LIMITED CIRCUMSTANCES INCLUDING RELEASE TO PERSONS WHO HAVE HARD RISK EXPOSURES. RELEASE PURSUANT TO AN ORDER OF THE COURT OR THE DEPARTMENT OF HEALTH CARE PROVIDERS OR RELEASE FOR STATISTICAL OR EPIDEMOLOGICAL PURPOSES. WHEN SUCH INFROMATION IS RELEASED IT CANNOT CONTAIN INFROMATION FROM WHICH YOU COULD IDENTIFIED UNLESS RELEASE OF THAT INDENTIFYING INFROMATION IS AUTHORIZED BY YOU, BY AN ORDER OF THE COURT OR THE DEPARTMENT OF HEALTH BY LAW.

5. This release may be revoked at any time and shall be valid no longer than is reasonably necessary to accomplish the purpose for which is given.

6. This release expires (12) twelve months following the date signed by me.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_

APPENDIX C. STATEMENT OF INCOME AND LIABILITIES

1. A. Are you or a household member working full-time or part-time and earning money?

[ ] Yes [ ] No If yes, complete the following information.

Employed Person	Employment	Monthly Take Home Pay
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B. Do you have transportation, if necessary for training or employment?

I certify that this information I have given is true, correct and complete to the best of knowledge. I agree to notify my Rehabilitation Services Counselor within 20 days if I have change in my living arrangement, address, income, bank accounts, automobiles, property of any kind, and expenses or needs.

I understand that the information I have given will be carefully studied and that I might be asked to provide proof of the answers given. I further understand that any false statement makes me subject to prosecution for fraud. I hereby authorize the Iowa Tribe of Oklahoma Vocational Rehabilitation Program (ITOVR) to make any necessary investigation to verify the information I have given.

When this form is returned, the ITOVR will review the information and discuss the services that can be provided and determine the amount of ay financial participation.

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Client/ Representative

Date

## IOWA TRIBE VOCATIONAL REHABILITATION PROJECT GENERAL HEALTH CHECKLIST

Full Name \_\_\_\_\_ Case # \_\_\_\_\_ Counselor \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Please checkmark if you have  
 any of the following symptoms  
 or condition.

If checked, has it kept  
 you from working?

	YES	NO
<input type="checkbox"/> 1. A disorder of eyes, ears, nose, or throat?	_____	_____
<input type="checkbox"/> 2. Frequent dizziness, fainting, or head: seizures, convulsions, paralysis or stroke?	_____	_____
<input type="checkbox"/> 3. A mental or nervous disorder?	_____	_____
<input type="checkbox"/> 4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of the lungs?	_____	_____
<input type="checkbox"/> 5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels?	_____	_____
<input type="checkbox"/> 6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gallbladder?	_____	_____
<input type="checkbox"/> 7. Disorder of kidneys, bladder, prostate, or reproductive system?	_____	_____
<input type="checkbox"/> 8. Diabetes, thyroid, or other endocrine disorders?	_____	_____
<input type="checkbox"/> 9. Arthritis or other disorder of the muscles or bones including spine, back or joints?	_____	_____
<input type="checkbox"/> 10. Absence of amputation of any body part?	_____	_____
<input type="checkbox"/> 11. Loss of use of arms or legs or other body parts?	_____	_____
<input type="checkbox"/> 12. A tumor, cancer, or disorder of the lymph glands	_____	_____
<input type="checkbox"/> 13. Allergies?	_____	_____
<input type="checkbox"/> 14. Anemia, or other disorder of the blood?	_____	_____
<input type="checkbox"/> 15. Excessive use of alcohol or any habit forming drugs?	_____	_____
<input type="checkbox"/> 16. Any other physical or mental condition?	_____	_____

If yes, specify: \_\_\_\_\_

17. Name and address of your personal physician/clinic: ( If none, so state)

\_\_\_\_\_

PLEASE ANSWER THESE QUESTIONS FOR ANY  
CONDITION MARKED "YES" ON THE FIRST PAGE:

18. Have you been or are being treated for any of these conditions?

Yes  No If Yes: Which ones? \_\_\_\_\_

\_\_\_\_\_

19. Have you been hospitalized for any of these conditions?  Yes  No

If yes, under what conditions: \_\_\_\_\_

\_\_\_\_\_

20. Are you taking any medications?  Yes  No

If yes, list medications: \_\_\_\_\_

\_\_\_\_\_

21. Do you have any restrictions from these conditions?  Yes  No

If yes, what restrictions: \_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, what I have said is true and I have not  
withheld any information.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Applicant)

Person who provided information, if not applicant: \_\_\_\_\_

## Certification of Eligibility for Federal Assistance in Certain Programs

I, understand that 34 CFR 75.60, 75.61, and 75.62 require that I make specific certifications of eligibility to the U.S. Department of Education as a condition of applying for Federal funds in certain programs and that these requirements are in addition to any other eligibility requirements that the U.S. Department of Education imposes under program regulations.

Under 34 CFR 75.60-75.62:

I certify that:

- A. I do not owe a debt, or I am current in repaying a debt, or I am not in default (as that item used at 34 CFR Part 668) on a debt.
1. To the Federal Government under a nonprocurement transaction (e.g., a previous loan, scholarship, grant, or cooperative agreement): or
2. For a fellow scholarship, stipend, discretionary grant, or loan in any program of the U.S. Department of Education of Education that is subject to 34 CFR 57.50, 75.61 and 75.62, including:
- Federal Pell Grant Program (20 U.S. 1070a, et seq)
  - Federal Supplemental Educational Opportunity Grant (SEOG) Program (20 U.S. 1070 (b), et seq
  - State Student incentive Grant Program (SSIG) 20 U.S. 1070c. et seq
  - Federal Perkins Loan Program (20 U.S.C. 1087aa, et seq)
  - Income Contingent Direct Loan Demonstration Project (20 U.S.C. 1087a, note);
  - Federal Stafford Loan Program, Federal Supplemental Loans for students [SLS], Federal PLUS, or Federal Consolidation Loan Program(20 U.S. 1071, et seq.),
  - Cuban Student Loan Program(20 U.S.C. 2601, et.seq),
  - Robert C. Byrd Honors Scholarship Program ( 20 U.S.C 1070d-31, et. seq)
  - Jacob K. Javits Fellows Program ( 20 U.S.C 1134h-1134)
  - Patricia Roberts Harris Fellowship Program( 20 U.S.C. 1134d-1134g)
  - Christa McAuliffe Fellowship Program (20 U.S.C 1105-1105j)
  - Bilingual Education Fellowship Program (20U.S.C 3221-3262)
  - Rehabilitation Long Term Training Program ( 29 U.S.C 774(b)
  - Paul Douglas Teacher Scholarship Program (20 U.S.C. 1104, et seq),
  - Law Enforcement Education Program (42 U.S.C. 3775)
  - Indian Fellowship Program (29 U.S.C. 774(b)

**OR**

B. I have made arrangements satisfactory to the U.S. Department of Education to repay a debt as described in A.1 or A.2 (above) on which I had not been current in repaying or on which I was in default ( as that term is used in 34 CFR part 668)

C. I certify also that I have not been declared by a judge, as a condition of sentencing under section 5301 of the Anti-Drug Abuse Act of 1988 (21 U.S.C. 862), ineligible to receive Federal assistance for the period of this requested funding.

I understand that providing a false certification to any of the statements above makes me liable for repayment to the U.S. Department of Education for funds received on the basis of this certification, for civil penalties, and for criminal prosecution under 18 U.S.C. 1001.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Typed or Printed)

# Request for Taxpayer Identification Number and Certification

Give form to the  
 requester. Do not  
 send to the IRS.

Print or type  
 See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Other (see instructions) ▶	
<input type="checkbox"/> Exempt payee	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

## Part III Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

## Part IV Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

#### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,