REFERRAL FORM
Shoshone-Paiute Tribes Vocational Rehabilitation

DATE:_____

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Middle Name: _____ Preferred Name: _____

Social Security #: _____ DOB:_____ Gender: ☐ Male ☐ Female

Previous Last Name:_____ I am a previous Voc Rehab Client: ☐ Yes ☐ No

If yes, where?: _____

ADDRESS INFORMATION

Physical Address:_____

City: _____ State:_____ Zip:_____ County:_____

Mailing Address:_____

City: _____ State:_____ Zip:_____ County:_____

Primary Phone: _____ ☐ Voice ☐ TDD ☐ Fax

Second Phone: _____ ☐ Voice ☐ TDD ☐ Fax

OTHER INFORMATION

Please verify your ethnicity by attaching your Certificate of Degree of Indian or Alaskan Native Blood to this application.

Special correspondence format needed?: ☐ No ☐ Audio Tape ☐ Braille ☐ Large Print

Special language needs: ☐ Yes ☐ No *If yes, explain*:_____

CONTACTS

(examples: family, friends, probation officer, parole officer, case worker, etc.)

	Name (first, last)	Relationship	Phone Information	Ext. #	Voice / TDD / Fax
1					
2					

3					

What are your current living arrangements? *(private residence, halfway house, shelter, etc.)*:

_____

Marital status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

If married, what is your spouse's name?:_____

How were you referred to Voc Rehab?:_____

Are you participating in any of the following programs? (select all that apply):

☐ Adult Correction
☐ General VR Kidney
☐ Juvenile Correction
☐ School-Work
☐ DJC Re-entry Program
☐ Migrant Service Coordination Grant Under 304
☐ Community Supported Employment
☐ IDOC Re-entry Program
☐ IDOC-CCE, Program 13
☐ Medicaid
☐ Medicare
☐ None

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

If yes, explain: _____

My Probation/Parole Officer is:_____ IDOC #: _____

Probation Start Date:_____ Probation End Date: _____ Restitution Owed: _____

Do you have a current & valid Driver's License?: ☐ Yes ☐ No *Explain*: _____

Are you a Veteran?: ☐ Yes ☐ No

FINANCIAL

Gross Annual Income:_____ # of family members living with you:_____ # of dependents:_____

Do you currently owe child support?: ☐ Yes ☐ No *If yes, amount:* $_____

What is your primary source of support? (current earnings, friends & family, public assistance, etc.):

_____

Is public support available to you?: ☐ Yes ☐ No ☐ Unknown

SSDI status: ☐ Allowed ☐ Denied ☐ Pending ☐ Terminated ☐ Not an applicant

SSI status: ☐ Allowed ☐ Denied ☐ Pending ☐ Terminated ☐ Not an applicant

	Cash	Other		Cash	Other
SSI Aged:	$_____	☐	Worker's Compensation:	$_____	☐
SSI Disabled:	$_____	☐	Other Disability:	$_____	☐
SSDI:	$_____	☐	Other:	$_____	☐
VA:	$_____	☐	TANF:	$_____	☐

Please specify which Medical Insurance(s) you may have by selecting one or more of the following:

☐ Medicaid

☐ Medicare

☐ Worker's Compensation

☐ None

☐ Private insurance through own employment
Provider: _____

☐ Public insurance from other source
Provider: _____

☐ Private insurance through other means
Provider: _____

EDUCATION

Last level of education completed (high school / GED / HSE / college): _____

Date completed: _____

Have you received services under an Individualized Education Program (IEP)?: ☐ Yes ☐ No

Are you currently a high school student participating in a transition program?: ☐ Yes ☐ No

If yes, what is the name of the school?: _____

EMPLOYMENT & WORK HISTORY

Are you currently employed?: ☐ Yes ☐ No

If yes, who is your employer?: _____

Work History

Starting with your current or most recent job, list your jobs on the following chart on page #4.

- The approximation of dates and salaries ARE needed
- Please make sure to include negative work history so that we better know your needs

	Employer Name & Address	Job Title	Job Duties	Start Date & End Date	# Hours Per Week	Salary: Starting & Ending	Reason For Leaving
1							
2							
3							
4							
5							

DISABILITIES

Have you been diagnosed or treated for any of the following disabilities? *Explain. (physical, injuries, mental health, depression, substance abuse (drug and/or alcohol), learning disability, etc.)*:

Does your disability make it difficult to *(describe how it affects you in the space provided)*:

☐ Stand ☐ Walk ☐ Sit ☐ Lift ☐ Bend ☐ Use hands or feet

Explain:_____

☐ See ☐ Hear ☐ Read ☐ Write

Explain:_____

☐ Concentrate ☐ Remember ☐ Learn ☐ Understand

Explain:_____

☐ Handle stress ☐ Control emotions ☐ Work with others ☐ Communicate

Explain:_____

☐ Other: _____

Explain:_____

DOCUMENTATION

How might Vocational Rehabilitation assist you in your employment endeavors?:

What are your employment needs?:

**********AGENCY USE ONLY**********

Next step in establishing eligibility:

Additional information or comments:

MEDICAL PROVIDER INFORMATION

Applicant Name:_____

The SPTVR staff looks forward to working as a partner with you in your vocational rehabilitation process ultimately leading toward your return to successful employment.

If you are unable to provide medical documentation of disabilities to your counselor, please provide contact information for medical providers who may have those records below. When you meet with your counselor you may be asked to sign releases of information for some or all of these medical providers.

In order to make a determination of eligibility for Vocational Rehabilitation services, we must have medical, psychiatric, and/or psychological information for all ongoing conditions. We have a deadline so we need it as soon as possible. (Note: Not having adequate records is a primary reason for a delay in eligibility determination).

Please begin to obtain all of these documents so that you can provide them to your counselor. Because of the HIPAA regulations, your doctors may ask you to sign a Release of Information. You can bring your records when you meet with your counselor or you can have the records faxed to SPTVR if it would be more convenient for you, or if the records would be coming from out of state. **Do <u>NOT</u> purchase records as we <u>CANNOT</u> reimburse you for the cost.**

Physician or Hospital Name	Address	Phone # (area code)	Fax # (area code)	Medical Reason for Visit

Signature: _____ Date: _____