Southern Ute Indian Tribe
Vocational Rehabilitation Program

P.O.Box 737, Ignacio, CO 81137
Ph: (970) 563-0100

APPLICATION FOR VOCATIONAL REHABILITATION SERVICES

Contact Information:

Date: _____

Name: _____
Last First M.I. Maiden

Other Name(s) Used: _____

Street Address: _____

Mailing Address: _____

City: _____State:_____ Zip: _____ County: _____

Telephone: Home:_____ Work:_____ Email: _____

Contact Person Name: _____ Phone: _____

Contact Person Address: _____

Personal Information:

SSN: _____-_____-_____ Birthdate: _____ Age _____ Gender: ☐ Male ☐ Female

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

Alaskan Native ☐ Native American ☐

Tribal Affiliation: _____ Enrollment #: _____

Driver's License/State ID #: _____ Issuing State: _____

I was referred by: _____

Were you ever involved with the legal system (court, jail, detention, probation, etc.)? ☐ Yes ☐ No

Explain: _____

_____

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Revised 05/01/09
Revised 10/6/11

Educational Information:

Highest grade completed:_____ G.E.D. ? ☐ Yes ☐ No If Yes, date received:_____

Educational Background: (List the school/trainings you have attended)

School	Course/Major	Diploma/Certificate Rcvd?	Month/Year Completed

Military Service Information:

Veteran: ☐ Yes ☐ No Military Branch: _____ Dates of Service: _____

Rank:_____ Discharge: Honorable ☐ Dishonorable ☐

Health Information:

Did you ever receive treatment for substance abuse or mental issues?: ☐ Yes ☐ No

If yes, when and where_____

Describe your disability(ies) and when it (they) began: _____

_____

_____

Please describe how you believe your disability (ies) limit(s) your employment: _____

_____

_____

Are you using any kind of brace or medical devise? If yes, what is it? _____

Is your disability the result of a work related accident? ☐ Yes ☐ No If yes, date of accident and employer:

_____

List Medications you take: _____

What kind of Health Insurance do you have? Please list any/all: _____
_____

Are you currently working with other agencies? ☐ Yes ☐ No If yes, list: _____
_____

Household Information:

Number of people living in your house: _____ How many are dependents? _____

MEMBERS OF YOUR HOUSEHOLD

Name(s)	Age	Relationship

Employment Information:

Employment status during the past week:

☐	Competitive labor market	☐	Not working/student	☐	Sheltered Workshop
☐	Not working/other	☐	Self employed	☐	Trainee
☐	Small business enterprise	☐	Homemaker	☐	Unpaid family worker

If you are currently employed, weekly earnings $_____ Number of hours per week _____

Did you ever work with our program before? ☐ Yes ☐ No

What assistance are you asking from the SUITVRP (work related)?_____
_____
_____

EMPLOYMENT HISTORY: Begin with your most recent job and include the job you had for the longest period of time. If you have a resume, please bring it in to include in your file.

Job Title:	Dates of Employment:	Salary:
Employer:	Address:	
Duties:		
Reason for Leaving:		
Does your disability keep you from returning to this type of job?		

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Employer:	Address:	
Duties:		
Reason for Leaving:		
Does your disability keep you from returning to this type of job?		

If you cannot list all of your jobs, how many jobs have you had since you started working?
What types of jobs have you had?

RELEASE OF VERIFICATION:
By signing this application, I am requesting services from the Southern Ute Indian Tribe Vocational Rehabilitation Program. I further certify that the information provided herein is correct. I understand that the SUITVRP may use my name and Social Security number to verify with the Social Security Administration the status of any Social Security benefits I may be receiving.

RESIDENCE CERTIFICATION:
In accordance with Section 121 (A) of the Vocational Rehabilitation Act of 1973 (amended 1998), I affirm that I live on or near the Southern Ute Indian Reservation, located in Colorado. I have submitted the appropriate documentation verifying my residency on or near the Southern Ute Indian Reservation.

CONFIDENTIALITY STATEMENT:
By signing this application, I understand that all submitted information will be held in confidentiality. Only pertinent information necessary in making a determination of my eligibility will be released on a need-to-know basis to other agencies. I have been informed of the process to file a complaint should I believe such confidentiality has been breached.

_____ _____
Signature of Client Date

_____ _____
Signature of Representative (if applicable) Date

_____ _____
Vocational Rehabilitation Representative Date