CHOCTAW NATION VOCATIONAL REHABILITATION

TO COMPLETE THIS APPLICATION YOU MUST PROVIDE A COPY OF
Tribal Membership
Social Security Card
Driver's license
Medical Reports or adequate information to send off for information
Residence verification (copy of utility bill or driver's license)

ALL INFORMATION MUST BE SUBMITTED WITH APPLICATION. APPLICATION WILL NOT BE PROCESSED UNLESS COMPLETE WITH ALL REQUESTED INFORMATION

Date of Application: ________________

Last Name ______________________ First Name __________________ Middle Initial ____

Home Address ____
(Street, Route, P.O. Box #, etc.)

Directions to Home ____

Mailing Address if different from above: ____

Phone Number ______________________ Cell Phone _______________________

E-Mail Address ____

DOB _________________ SSN __________________________ Sex ☐ Male ☐ Female

MARITAL STATUS: ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated

TRIBAL AFFILIATION:____

WHAT IS YOUR DISABILITY AND HOW DOES IT LIMIT YOUR ABILITY TO WORK?

____
____
____
____

WHEN DID YOUR DISABILITY OCCUR?

____

MEDICAL HISTORY:

Are you currently or have you previously been treated for your disability? ☐ Yes ☐ No

If **yes**, list

1. ____

Name & address of Doctor/Hospital Phone Number

2. ____

Name & address of Doctor/Hospital Phone Number

3. ____

Name & address of Doctor/Hospital Phone Number

Have you ever applied for or participated in Vocational Rehab?
☐ Yes ☐ No If yes, When? ______________ Where ______________

Who referred you to our program? ______________________________

How may the Choctaw Nation Vocational Rehabilitation Program assist you?

____

____

____

List three people that CNVR may contact to locate you if we are not able to contact you.

1. Last Name ______________ First Name ______________
   Relationship ______________ Address ______________
   Home phone ______________ Cell or work phone ______________
   E-Mail address ______________________________

2. Last Name ______________ First Name ______________
   Relationship ______________ Address ______________
   Home phone ______________ Cell or work phone ______________
   E-Mail address ______________________________

3. Last Name ______________ First Name ______________
   Relationship ______________ Address ______________
   Home phone ______________ Cell or work phone ______________
   E-Mail address ______________________________

Number of family living in your household ____
List All Household Members With Income Information
(Include Wages, SSI, SSDI, TANF, Worker's Comp., Unemployment, etc.)

Name	Relationship	Source of Income	Monthly Amount
	Self		

Do you have and of the following (please check one):
☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Public Insurance ☐ None

EDUCATION HISTORY:

	School Name	City & State	Area of Study	Graduated
High School				
Technical				
College				
Other				

WORK HISTORY (List your last three jobs):

Employer Name & Address	Job Title	Hourly Wage & # hours per week	Dates Employed (Beginning & Ending)	Reason for leaving

Have you ever been convicted of a felony or do you have charges pending which may result in a felony conviction? ☐ Yes ☐ No
Explain: ____
Have you ever defaulted on a student loan? ☐ Yes ☐ No
Do you have a valid driver's license? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No If yes, list serial number and dates of service ___________
Do you have a Military Service Connected Disability? ☐ Yes ☐ No

CHOCTAW NATION VOCATIONAL REHABILITATION

GENERAL HEALTH CHECKLIST

Full Name ___________________________ Social Security Number ______________________

Date of Birth ________________ Height _______________ Weight ____________

Please answer "Yes" or "No" to all items.

Do you have….	**YES**	**NO**	**IF YES, HAS IT KEPT YOU FROM WORKING? YES**	**NO**
1. A disorder of eyes, ears, nose or throat?	☐	☐	☐	☐
2. Frequent dizziness, fainting, or headache; seizures, convulsions, paralysis, or stroke?	☐	☐	☐	☐
3. A mental or nervous disorder?	☐	☐	☐	☐
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs?	☐	☐	☐	☐
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 part?	☐	☐	☐	☐
11. Loss of use of arms and legs or other body part?	☐	☐	☐	☐
12. A tumor, cancer, or disorder of skin or lymph glands?	☐	☐	☐	☐
13. Allergies?	☐	☐	☐	☐
14. Anemia or other disorder of the blood?	☐	☐	☐	☐
15. Excessive use of alcohol or any habit-forming drugs?	☐	☐	☐	☐
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 you being treated for any of these conditions? ☐ YES ☐ NO

If **NO**, why not? ____

If **YES**, Condition	Dr. Name & Address	Phone Number	Dates Seen

19. Have you been hospitalized for any of these conditions? ☐ YES ☐ NO

If YES, Condition	Hospital	When?

20. Are you taking any medicines? ☐ YES ☐ NO

If YES, Condition	Medicine	Condition	Medicine

21. Do you have any restrictions from these conditions? ☐ YES ☐ NO

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: ______________________

Comments: