COOK INLET TRIBAL COUNCIL
People. Partnership. Potential.

Tribal Vocational Rehabilitation Program Application for Services

3600 San jeronimo Dr. suite, 230 Anchorage, AK 99508
Direct: 907-793-3360 | **Fax:** 907-793-3398 | **www.citci.org**

If you need assistance completing this form or have questions, please reach out to CITC staff.

Congratulations on taking the first step towards gainful employment!
Here's what you can expect moving forward.

Orientation
Our team wants to make sure you feel informed and confident throughout the process. During your orientation, we'll answer any questions you have and help you feel prepared to move forward. This is where you'll learn more about our program and how we can help you achieve your career goals.

Apply and submit
You're working on this step, but don't worry! Our team will guide you through the rest of the process.

Find out if you qualify for services
With this form, there will be a *Release of Information* (ROI) form included to request for diagnostic records from your medical provider or treatment center. Our team will keep you updated on the status of your application and what you need to do to qualify for our services.

- TVR staff will be in touch with you shortly to schedule your *Application Intake Appointment.*
- On average, it can take between *1 - 4 weeks* for records to reach us. Feel free to check in to see if we received them.

Your plan
Together with your TVR Case Manager, we will create a personalized plan that meets your unique needs and career goals. Our team can help you identify your interests, talents and connect you with the right job opportunities. The written plan will outline the steps you need to take to reach your job goal. This *Individualized Plan for Employment* (IPE) is your roadmap to success.

Identify your job goal and plan the services you need
We believe that every person has the potential to succeed in their chosen career. That's why we work with you to create a job goal that fits your disability and the current job market. We will help you find the services you need to achieve your goals.

Complete the IPE & receive services
Once you and your TVR Case Manager have agreed on your IPE, you can start receiving the services you need to achieve your career goals. Our team will be there to support you every step of the way.

Job search and employment action
Search for and get a job; We're here to help you find job openings that align with your career goals, and we'll provide any assistance you need for gainful employment.

Follow up and close your case
Our team will check in with you for 90 days after you find a job to ensure that everything is going well. If all is going smoothly, we'll successfully close your case. However, if you need additional support, you can always ask us for "Post-Employment" services to help you keep your job, get your job back, or move up in your career.

Information Page - Request copies for your records.

General Information *Please Print Legibly*

First Name | Middle Name | Last Name | Other Names Used | Suffix.

Social Security Number | Date of Birth (xx/xx/xxxx) | Male or Female

Home/Physical Address | City | State | ZIP

Mailing Address (if different from home address) | City | State | ZIP

Primary Phone Number | Other Phone Number

E-mail Address | Other E-mail Address

Alaska Native Ethnicity (check one or more)

- ☐ Aleut
- ☐ Alutiiq
- ☐ Athabascan
- ☐ Eyak
- ☐ Haida
- ☐ Inupiat
- ☐ Yup'ik/Cup'ik
- ☐ Tlingit
- ☐ Other:

Tribal Enrollment Corporation (check one or more)

- ☐ knik
- ☐ Chickaloon
- ☐ Kenatize
- ☐ Seldovia
- ☐ Eklutna
- ☐ Tyonek
- ☐ Ninilchick
- ☐ Salamatof
- ☐ Other:

Corporate Affiliation (check one or more)

- ☐ AHTNA
- ☐ ASRC
- ☐ BSNC
- ☐ BBNC
- ☐ Calista
- ☐ CIRI
- ☐ Chugach
- ☐ NANA
- ☐ Other:

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living Situation

☐ Own ☐ Rent ☐ Shelter ☐ Friend/Family ☐ Homeless

United States Citizen?

☐ Yes ☐ No

Registered for selective service?

☐ Yes ☐ No ☐ N/A

Veteran?

☐ Yes ☐ No ☐ N/A

Educational Status

☐ High School Diploma ☐ GED ☐ No Diploma/GED ☐ Some College/ No Degree ☐ Vocational Training ☐ College Graduate

This application is valid up to one year from date of submission.

Please include copies of the following documents with your application:

- State Identification Card or Passport [required]
- Certificate of Indian Blood (CIB) with Tribal Enrollment Verification [required]
- Latest resume *(optional)*
- Copies of medical records about your disability

(if you don't have them, CITC can obtain records from your doctor with your permission)

Social Supports

Do you have a support system?

☐ Yes ☐ No If yes, who?: _____

Number of Children if any: _____

Number of grandchildren if any: _____

Time in Alaska & Anchorage?: _____

Recreational & Leisure Activities: _____

Do you have a mode of transportation? ☐ Yes ☐ No Type: _____

Emergency Contact Information:

Name: _____ Relation: _____

Phone Number: _____ Email Address (optional): _____

Medical Information

The TVR Program will request for medical records with the Release of Information form (ROI), but you're welcome to turn them in yourself anytime.

Please list medical disabilities: _____

Are you currently in treatment? ☐ Yes ☐ No ☐ N/A | If Yes, _____ (where & when)

Have you completed alcohol/drug treatment? ☐ Yes ☐ No ☐ N/A | If Yes, _____ (where & when)

Was your disability due to a work injury? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

Name of your primary medical provider? _____

Name of your secondary medical provider? _____
(optional)

Have you completed a Substance-Use Assessment in the last 3 years? ☐ Yes ☐ No ☐ N/A | If Yes, _____ (where & when)

Please mark if you experience difficulties performing any of the following:

- ☐ Standing
- ☐ Sitting
- ☐ Lifting
- ☐ Bending
- ☐ Verbal Communication
- ☐ Written Communication
- ☐ Reaching
- ☐ Using a Computer
- ☐ Seeing
- ☐ Hearing
- ☐ Typing
- ☐ Reading
- ☐ Writing
- ☐ Understanding
- ☐ Processing Information
- ☐ Learning
- ☐ Handling Stress
- ☐ Controlling Fear
- ☐ Controlling Emotions
- ☐ Concentrating
- ☐ Getting Along with Others
- ☐ Controlling Alcohol/Drugs
- ☐ Feeling Confident
- ☐ Remembering

Vocational Goals

Are you Currently Employed? ☐ Yes ☐ No

Field of employment you're interested in: _____ ☐ Full-Time ☐ Part-Time

Minimum Wage Accepted: $ _____ /per _____ ☐ Month ☐ Year

Have you applied/received Vocational Rehabilitation Services before? ☐ Yes ☐ No

Are you interested in working in cooperation with Alaska Division of Vocational Rehabilitation? (DVR) ☐ Yes ☐ No

What particular support are you seeking from the TVR Program? (optional) _____

Financial

Please mark all that apply:

☐ SSI/SSDI	☐ Medicaid	☐ Medicare	☐ Indian Health Service (IHS)
☐ Private Insurance	☐ Food Stamps	☐ TANF/GA	☐ Workers Compensation
☐ Adult Public Assistance	☐ Child Support	☐ ATAP	☐ Retirement Fund
☐ VA Disability	☐ VA Benefits	☐ AK-PFD	☐ Unemployment

Legal

Note: *If there is an open criminal case against you, TVR will process this application, but cannot continue onto the next steps until your case is closed. Please reach out to TVR staff to learn more.*

Valid Driver's License? ☐ Yes ☐ No

Do you have any open criminal cases? ☐ Yes ☐ No If Yes, _____ (Projected Closure Date)

Felonies? ☐ Yes ☐ No If Yes, _____ (please list)

Misdemeanors? ☐ Yes ☐ No If Yes, _____ (please list)

DUI/DWI? ☐ Yes ☐ No

_____

(Parole/Probation Officer Name) | Officer's Phone Number and/or E-mail Address | Restrictions?

By signing this application, I _____, am requesting services from Cook Inlet Tribal Council, Inc., Vocational Rehabilitation Program. I further certify that the information provided herein is correct. I understand that Cook Inlet Tribal Council, Inc., Vocational Rehabilitation Program may use my information to verify with the Social Security Administration the status of any Social Security benefits I may be receiving.

_____
Signature

_____
Parent | Guardian Signature

_____
Date

_____
Date

Cook Inlet Tribal Council, Inc.
Tribal Vocational Rehabilitation Program
3600 San Jeronimo Drive; Anchorage, AK 99508
907-793-3360; *Fax:* 907-793-3398 www.citci.org

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

By my signature below, I acknowledge receipt of the Notice of Privacy Practices for the Cook Inlet Tribal Council, Inc.

Signature of Individual or Authorized Representative	Date
Printed name	Relationship

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Rights and Responsibilities

CITC PARTICIPANTS COMPLAINTS AND FEEDBACK
If you are unhappy with the services offered, or the way you are treated, you must follow the participant complaints and feedback procedure outlined in CITC Procedure #9.010.010. The first step in either a complaint or feedback is to contact the staff with whom you have a complaint/feedback to discuss or attempt to resolve the disputed action. If you are unable to resolve the disputed action with the staff, you then meet with the staff's supervisor who will work with you to resolve the complaint or receive your feedback. For a complaint, if it remains unresolved, a formal complaint can be filed with the supervisor who will bring that complaint to the appropriate member of leadership for further action. Participants may request a change of case manager based on their personal preference, however at any point in time this may not be possible due to staffing availability.

- Be treated with respect by CITC staff and treat CITC staff with respect.
- Be treated without regard to race, color, creed, national origin, religion, sex, sexual preference, disability or age.
- Be treated with all safety measures being taken into consideration.
- Have all personal information treated in a confidential manner.
- Review consumer file with appropriate staff present.
- Be fully informed regarding any and all fees associated with services received at CITC TVR.
- Be given clear information regarding participation in all program activities.
- Follow CITC TVR program rules and regulations.
- Actively participate in decisions made in regards any services received from CITC TVR.
- Inform CITC TVR staff of any changes in consumer information, such as name, address, phone number, etc.
- Ask for clarification regarding any services received from CITC TVR.

AMERICANS WITH DISABILITIES ACT OF 1990
Cook Inlet Tribal Council, Inc. complies with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the CITC Corporate Affairs Officer at (907) 793-3407. ETSD does not provide medication management and does not provide a designated room for medication monitoring. CITC TVR is not able to release any medical documentation that is submitted or received in connection to an application for services.

Printed Name: _____

Signature: _____

Date: _____

AUTHORIZATION TO FOR CITC/CSELC/ANJC TO OBTAIN PERSONAL INFORMATION

Name: Birthdate:

Other Names Used:

I authorize release of my information BY: _____

My information may be released TO:

☐ Cook Inlet Tribal Council ☐ Clare Swan Early Learning Center ☐ Alaska Native Justice Center

My **Contact Person** at CITC/CSELC/ANJC is: _____. If records include 42 CFR Part 2 records, this is to be the person who is authorized at the entity to receive the records.

Provide the information to CITC/CSELC/ANJC: *Check all that apply*

☐ **Verbally:** Participant information may be discussed between the individual/organizations named above

☐ **By Mail:** _____
Street Address or P.O. Box City State Zip

☐ ***By Fax:** _____

☐ ***By Email:**

* *Using Fax/Email may increase certain privacy risks including risk of accidental disclosure & cyberattack.*

The following information is authorized to be disclosed/sent to the party stated above: *Describe the information or documents that are required for the benefit/program being applied for:*

I have been given sufficient time to read, understand, and ask questions about this form, and I understand the following:
HIPAA: I have a right to: (1) receive a copy of this signed authorization upon request; (2) refuse to sign this form/authorization; and (3) inspect or copy my information. I understand an entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form, unless it is necessary for the entity's proper treatment of me, obtaining payment for my services, or its healthcare operations. I may arrange to inspect or copy information by contacting CITC. **42 CFR Part 2:** Substance Use Disorder treatment information is protected under the federal regulations governing the confidentiality of SUD patient records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Recipients of my information pursuant to this authorization may not further disclose my substance use disorder information without my consent, unless specifically allowed under 42 CFR Part 2 or HIPAA. Recipients will be notified of this obligation in the Prohibition on Re-Disclosure which must accompany all disclosures of my substance use disorder information. **VAWA:** Information covered by Violence Against Women Act may be disclosed and I understand the type of information, reason for sharing, and potential recipients authorized in this release under this release.

Why are you requesting this disclosure?

☐ Care Coordination ☐ Legal ☐ School/Education ☐ Employment/Benefits ☐ Other:_____

Expiration: This authorization expires **2 years** from the date signed *or* this requested date:_____/_____/_____

Revocation: I understand I may revoke authorization at any time by notifying the Person or Organization I am authorizing to release records. I may also notify my contact person at CITC of a revocation and they will withdraw the request for records. Revocation is not effective until received and is not effective for disclosures already made in reliance on the authorization.

I authorize disclosure of the requested records and understand they may contain sensitive information.

Signature: _____ **Print Name:** _____ **Date:** _____

Address: _____
Street Address or P.O. Box City State Zip

Relationship to Participant: ☐ Self ☐ *Parent/Guardian ☐ *Legally Authorized Representative

* *Attach proof of relationship to the Participant of parent/guardian or legally authorized representative.*

Minor's Signature, if 42 CFR Part 2 records about Minor:_____ **Date:**_____

YOU MUST SUBMIT A COPY OF A VALID PHOTO ID WITH THIS REQUEST

AUTHORIZATION TO FOR CITC/CSELC/ANJC TO OBTAIN PERSONAL INFORMATION

Name: Birthdate:

Other Names Used:

I authorize release of my information BY: _____

My information may be released TO:

☐ Cook Inlet Tribal Council ☐ Clare Swan Early Learning Center ☐ Alaska Native Justice Center

My **Contact Person** at CITC/CSELC/ANJC is: _____. If records include 42 CFR Part 2 records, this is to be the person who is authorized at the entity to receive the records.

Provide the information to CITC/CSELC/ANJC: *Check all that apply*

☐ **Verbally:** Participant information may be discussed between the individual/organizations named above

☐ **By Mail:** _____
Street Address or P.O. Box City State Zip

☐ ***By Fax:** _____

☐ ***By Email:**

* *Using Fax/Email may increase certain privacy risks including risk of accidental disclosure & cyberattack.*

The following information is authorized to be disclosed/sent to the party stated above: *Describe the information or documents that are required for the benefit/program being applied for:*

I have been given sufficient time to read, understand, and ask questions about this form, and I understand the following:
HIPAA: I have a right to: (1) receive a copy of this signed authorization upon request; (2) refuse to sign this form/authorization; and (3) inspect or copy my information. I understand an entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form, unless it is necessary for the entity's proper treatment of me, obtaining payment for my services, or its healthcare operations. I may arrange to inspect or copy information by contacting CITC. **42 CFR Part 2:** Substance Use Disorder treatment information is protected under the federal regulations governing the confidentiality of SUD patient records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Recipients of my information pursuant to this authorization may not further disclose my substance use disorder information without my consent, unless specifically allowed under 42 CFR Part 2 or HIPAA. Recipients will be notified of this obligation in the Prohibition on Re-Disclosure which must accompany all disclosures of my substance use disorder information. **VAWA:** Information covered by Violence Against Women Act may be disclosed and I understand the type of information, reason for sharing, and potential recipients authorized in this release under this release.

Why are you requesting this disclosure?

☐ Care Coordination ☐ Legal ☐ School/Education ☐ Employment/Benefits ☐ Other:_____

Expiration: This authorization expires **2 years** from the date signed *or* this requested date:_____/_____/_____

Revocation: I understand I may revoke authorization at any time by notifying the Person or Organization I am authorizing to release records. I may also notify my contact person at CITC of a revocation and they will withdraw the request for records. Revocation is not effective until received and is not effective for disclosures already made in reliance on the authorization.

I authorize disclosure of the requested records and understand they may contain sensitive information.

Signature: _____ **Print Name:** _____ **Date:** _____

Address: _____
Street Address or P.O. Box City State Zip

Relationship to Participant: ☐ Self ☐ *Parent/Guardian ☐ *Legally Authorized Representative

* *Attach proof of relationship to the Participant of parent/guardian or legally authorized representative.*

Minor's Signature, if 42 CFR Part 2 records about Minor:_____ **Date:**_____

YOU MUST SUBMIT A COPY OF A VALID PHOTO ID WITH THIS REQUEST

******FOR INTERNAL USE ONLY*** THIS FORM IS NOT TO BE SENT OUTSIDE OF CITC/ANJC/CSELC/GOTNV**

Cook Inlet Tribal Council, Inc. / Alaska Native Justice Center / Clare Swan Early Learning Center / Get Out the Native Vote
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907)-793-3600; Fax (907)-793-3423

Authorization to Release Personal Information Within CITC and Related Entities[1]

Participant's Name: _____ DOB: _____ Month/Day/Year Last four digits of SSN: _____

☐ Participant ☐ Parent ☐ Legal Guardian authorizes CITC and related entities to:

_____ (Initial) Release protected health and other information as indicated below. **Please mark any records to be shared within CITC and related entities.**

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. I understand that although this ROI provides CITC and related entities with the authority to release my information within CITC departments and related entities, CITC policies require that only the minimum necessary information be released for the provision of services. Other specifications, if any:

_____

_____

Psychotherapy Notes, as defined by HIPAA, CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records. Nothing listed on this ROI is considered Psychotherapy Notes.

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION RELEASED: (circle and initial all that apply)

W / E / V ____Admission Summary
W / E / V ____Application for Services
W / E / V ____Attendance/Progress Report
W / E / V ____Career Development Assessment
W / E / V ____Discharge Status
W / E / V ____Education Assessments*
W / E / V ____FAS/FASD Assessments
W / E / V ____Health History/Physical Records
W / E / V ____Household composition
W / E / V ____Housing
W / E / V ____Immunization Records
W / E / V ____IT/legal/accounting
W / E / V ____Income and Wages
W / E / V ____Lab Reports (OCS and PO)
W / E / V ____Legal History
W / E / V ____Medication Records
W / E / V ____Medication Records–Substance Abuse
W / E / V ____Psychiatric Evaluation
W / E / V ____Psychological Evaluation
W / E / V ____Psychosocial History
W / E / V ____Service Plan (non-clinical)
W / E / V ____Supportive Services
W / E / V ____Treatment Plan (clinical)
W / E / V ____Treatment Recommendations for Level of Care (residential or outpatient)
W / E / V ____Other(specify)

_____

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies, information covered by the Violence Against Women Act (VAWA), and other information through Q and/or Parent Connect and other resources between CITC and related entities and ASD, and within CITC and related entities. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time.**_____(initial)

1. I understand that: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.
2. I understand that: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization, I must do so in writing and present my written revocation to CITC for PHI records, and in writing *or orally for substance use disorder treatment records;* (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
   Unless otherwise revoked, this authorization will expire on the following date:_____. If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.
3. I understand that my alcohol and/or drug treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and its enacting regulations, and that, depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. *I understand that only health information covered by 42 C.F.R. Part 2 (i.e., alcohol and drug use or treatment) will continue to be protected by law from redisclosure once it leaves CITC.* However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records that are subject to HIPAA cannot be disclosed by CITC or related entities beyond what is permitted under this authorization, without my written consent unless provided for by regulation.
4. I understand that information covered by VAWA may be disclosed and understand the type of information, reason for sharing and potential recipients.
5. ☐ **_____ (Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**
   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

Signature _____ **Date** _____

Signature of Guardian/Parent/Authorized Person _____ **Relationship to Participant** _____ **Date** _____

Printed Name _____

Signed copy received by participant: ☐ ____Yes (init) ☐ _____No, participant declined copy. (init)

Billing Entities potentially receiving information: AETNA; Affiliated Computer Services, Inc(Medicaid); AK PipeTrade Local 367 Health and Security; AK Electrical Health and Welfare Fund; AK HERE Health and Welfare Trust; AK Rural Employee Benefit Trust; Alaska Labors; Alaska U.C.F.W.Trust; Ameriben/IEC Group; ASEA/AFSCME Local 52 Health Benefits Trust; Blue Cross Blue Shield; Chanlyut; First Choice Health PPO Plan; Great West Health Care; Health and Welfare Benefits System; Healthcomp; Maritain Health; ODS Select Network Group; PGBA/Tricare; Principal Financial Group; Providence Health Plan; PS5 Health Plan Solutions; Risk Benefits Management Services; Salvation Army; SOAK Carpenters Health & Security Plan; SOA Office of Children's Services; American Postal Workers Union Health Plan; Zenith Administrators

Family Educational Rights and Privacy Act (FERPA):
This Authorization to Release Personal Information within CITC is governed by The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 C.F.R. Part 99), which protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education, including the Anchorage School District.

[1] "CITC and related entities" include the Alaska Native Justice Center, Inc. (ANJC), Clare Swan Early Learning Center (CSELC), and Get Out the Native Vote (GOTNV)