Inupiat Community of the Arctic Slope
**Vocational Rehabilitation**
P.O. Box 1610
Barrow, AK 99723
Tel: (907) 852-2448 or (888) 734-2448 Fax: (907) 852-2449

## APPLICATION FOR VOCATIONAL REHABILITATION SERVICES

All information provided is confidential and can only be used for determination of eligibility and possible vocational rehabilitation services.

1. Name:_____
2. Name you wish to be called:_____
3. Home Street Address:_____
4. Mailing Address: _____
5. SSN#:_____Date of Birth:_____
6. Marital Status: Single Married Divorced Widow(er) Significant Other
7. Home Phone: Cell Phone: Message Phone:
8. Name 2 people not living with you who can be contacted & know your address:

   _____Phone:_____
   Name (Relationship)

   _____Phone: _____
   Name (Relationship)
9. My disabilities are:_____
10. I am requesting the following services:_____
11. What type of employment would you like?_____
12. Who referred you to Vocational Rehabilitation?_____
13. Have you been a client of Tribal Vocational Rehabilitation? Yes No
14. Have you been a client of State Vocational Rehabilitation? Yes No
15. I am requesting services from (please circle which programs you want):

Tribal Vocational Rehabilitation State Vocational Rehabilitation Both Programs

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Applicant Signature:_____ Date :_____

Parent or Guardian:_____ Date:_____

Counselor's Signature:_____ Date Received:_____

Inupiat Community of the Arctic Slope

**Vocational Rehabilitation**

# CLIENT RIGHTS & RESPONSIBILITIES & DISCLOSURE

- To participate fully in the development of your own Individual Plan of Employment (IPE).
- To be treated with dignity and to treat others with dignity.
- To have your eligibility for services determined within 60 days of receipt of application, unless there are circumstances that require an extended amount of time.
- To have a fair and complete evaluation to determine eligibility that you will assist with as needed.
- To have degreed and trained Vocational Rehabilitation Counselors/Staff or to be supervised by one & learn what those degrees and training have been.
- To have your records and communications kept confidential. Information will not be released without your authorization, unless under court order.
- To make informed choices during your vocational rehabilitation experience.
- To be provided information on your rights of due process and the appeal process.
- To be provided information about the Client Assistance Program (CAP) for problem resolution.
- To access and receive services in a reasonably barrier free environment, including communication in an alternate format as needed.
- To reasonably receive appropriate Assistive Technology for assessment or services leading to a job.

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- If the Vocational Rehabilitation Counselor has knowledge that you are going to harm yourself or others, he/she is required to notify the proper authorities or officials.
- If the Vocational Rehabilitation Counselor believes you are going to harm or endanger or abuse children or elderly, he/she will report this to state or local authorities.
- If you are a minor or not your own legal guardian, then the information in your file may be available to your legal guardian or advocate.

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- To take an active role in the development & implementation of your Individual Plan of Employment.
- To request disability related accommodations you may require .
- You are to apply for and secure funding for which you may be eligible such as financial aid, insurance, Veterans benefits, and any fees or billing arrangements.
- To actively participate and maintain regular contact with the Vocational Rehabilitation Program.
- To talk to the VR Counselor if you are having a problem that is affecting your IPE.
- To actively seek and gain employment.

I have reviewed this page. The Vocational Rehabilitation Counselor has answered all questions I have about my rights, responsibilities, and disclosures, though I know I may ask questions about them at any time I'm receiving services. I have received my own copy of this form.

Client Signature:_____ Date: _____

# TRIBAL VOCATIONAL REHABILITATION
# GRIEVANCE PROCESS

Vocational Rehabilitation staffs are committed to providing professional quality assistance and support for individuals with disabilities. *If, as an applicant or participant with TVR, you do not agree with a decision or action taken by TVR, you have the right to appeal.* First, try to resolve problems with your counselor or program manager. They may be willing to consider other options and will give you valid reasons if alternatives are not appropriate. Most disagreements can be resolved at this level.

**YOU CAN**

- Discuss the situation with your counselor, or TVR Program Manager.
- Call the Client Assistance Program (CAP), an advocacy service independent of TVR, for assistance. (800) 498-2960 Fairbanks or (800) 478-0047 Anchorage
- Ask for an Administrative Review, Mediation, and a Fair Hearing.

**CLIENT ASSISTANCE PROGRAM**

You may request assistance from the CAP to help resolve problems or misunderstandings with your counseling team that may occur during your rehabilitation program. CAP is independent of ICASVR and provides advocacy and information free of charge. Your counselor will give you a brochure with additional information about CAP.

**THE APPEAL PROCESS**

If you are unable to resolve problems through the assistance of your TVR Counselor or TVR Program Manager and CAP, you have the right to request an Administrative Review, Mediation, or a more formal hearing before an impartial hearing officer. ***You must start the appeal process in writing within 30 days of the decision or action with which you disagree.***

**ADMINISTRATIVE REVIEW**

An administrative review is an informal meeting with the TR Counselor or TVR Program Manger. This individual will attempt to resolve the issue to your satisfaction. You must request the review in writing and: 1. Include the date of the decision or action you want to have reviewed. 2. Describe the decision or action you need to have resolved. 3. Include your name, address and telephone number, and if appropriate, that of your representative. 4. Sign and mail to: Program Manager; P.O. Box 1610; Barrow, AK 99723.

**MEDIATION**

Mediation is an alternative dispute resolution process where a trained impartial mediator attempts to help both parties seek an agreement to their differences. Your request for mediation must be made to the Program Manger of ICAS, TVR. Mediation is voluntary on the part of both parties.

**FAIR HEARING**

A Fair Hearing is a formal review process. Legal fees are not paid by TVR, but you may obtain assistance to prepare for this hearing through CAP. You will present your disagreement to a review board consisting of at least 3 of the following persons: ICAS TVR, Program Manager, ICAS Executive Director, representative from State DVR, representative from another tribal VR program within Alaska, another consumer of TVR services. The review board will hear your disagreement in person or via teleconference within 15 working days of your request. To request a Fair Hearing, submit a written request to ICAS TVR Program Manager including the date of the decision or action you want to have reviewed, a description of the decision or action you want to have resolved, your name, address and telephone number (and if appropriate, that of your representative). Sign and mail the request to Program Manager, ICAS TVR, P.O. Box 1610; Barrow, AK. 99723.

*I have reviewed the above Grievance Procedure. My vocational rehabilitation counselor has answered all questions I have about these procedures, though I know I may ask questions about my rights or responsibilities at any time while receiving services. I have received my own copy of this form.*

_____ _____

**Client Signature** **Date**

# ICAS Vocational Rehabilitation Program

## Involuntary Discharge and Termination From Program Criteria

Client may be discharged from the program for any of the following reasons:

1. Any threats, intimidation or act of violence directed towards staff members or other clients.
2. Bringing drugs, alcohol or weapons on premises.
3. Three unexcused absences from regularly scheduled appointments, including substance abuse, mental or physical health or others as documented in IPE.
4. Attempts to steal from and/or cause the loss of program property, or property belonging to staff or other clients.
5. Conviction and incarceration for crimes that place clients outside boundaries for a period in excess of one year.
6. A determination by program staff that the client is not amenable to rehabilitation: e.g. client fails to participate or lacks the ability to participate.
7. Giving false or misleading statements, information and documentation.
8. Violating a Client Contract/Agreement.

I have read the above and agree to the conditions numerated and voluntarily consent to the conditions and treatment.

Client signature _____ Date _____

Staff signature _____ Date _____

IHS-810 (12/04)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. *(Name of Patient)*

II. The information is to be disclosed by:

| NAME OF FACILITY | And is to be provided to: NAME OF PERSON/ORGANIZATION/FACILITY |
|---|---|
| Samuel Simmonds Memorial Hospital | ICAS Vocational Rehabilitation Program |
| ADDRESS: 1296 Agvik St | ADDRESS: P.O. Box 1610 |
| CITY/STATE: Barrow, AK 99723 | CITY/STATE: Barrow, AK 99723 |

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☒ Disability ☒ Other *(Specify)* Voc. Rehab Services

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Entire Record
☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify)* _____
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event.*

_____
*(Enter if different from one year after date below)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE *(State relationship to patient)* or *Witness (if signature is thumbprint or mark)* _____ DATE _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

| NAME (Last, First, MI) | RECORD NUMBER |
|---|---|
| ADDRESS | |
| CITY/STATE | DATE OF BIRTH |

PSC Media Arts (301) 443-1090

DEPARTMENT OF HEATH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

# AUTHORIZATION FOR RELEASE OF INFORMATION

Each section must be completed

I. I, _____, hereby request the disclosure of information from my record.
(PATIENT'S NAME)

II. The information is to be released from:

**ALASKA NATIVE MEDICAL CENTER**
**HEALTH INFORMATION SERVICES**
**4315 DIPLOMACY DRIVE**
**ANCHORAGE, ALASKA 99508**
**Fax: 907-729-3001**

REQUESTS FOR INFORMATION TAKE 3-5 BUSINESS DAYS TO BE PROCESSED.

and is to be provided to:
Name of Person/Organization/Facility ICAS VOCATIONAL REHABILITATION
Address PO BOX 1610
City/State BARROW, ALASKA 99723

**III. The purpose or need for this disclosure is:**

To Receive Vocational Rehabilitation Services

IV. **The information to be released is from my:** (*Check one*)
[ ] Medical Record [ ] Personnel Record [ ] Other (*specify*)_____
and includes: (*Check as appropriate*)
[ ] The entire record, including any information on alcohol or drug abuse contained therein.
[ ] Only information related to (*specify*)_____
[ ] Only the period or events from:_____ to_____

V. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature.

**Signature of Patient**_____ Date_____
**Signature of Parent, Guardian**
**or Authorized Representative**(*if necessary*)_____ Date_____

**This information is to be released for the purpose stated above and my not be used by the recipient for any other purpose. Any person knowingly and willfully requests of obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CRF 2.31(d).**

PATIENT'S IDENTIFICATION

*For Pick-Up, please include phone number

NAME (*First, M.I., Last*) RECORD NUMBER

ADDRESS


# IÑUPIAT COMMUNITY of the ARCTIC SLOPE

An IRA Regional Tribal Government

Vocational Rehabilitation Program, P.O Box 1610 • 3210 Brower Street • Barrow, Alaska 99723
Ph: (907)852-2448 Toll Free 1(888)734-2448 Fax: (907)852-2449


## Limited Release of Information

**Client Name:** _____

**Client Address:** _____

The information is to be released To and/or From:

Name of Organization/Person: Auditors
Address: c/o ICAS Vocational Rehabilitation
P.O. Box 1610
Barrow, AK 99723

AUTHORIZATION

I authorize the ICAS Vocational Rehabilitation Program to share only the minimal required information with the auditors that shows them that the ICAS Program has provided eligibility for me with the appropriate documentation as is required for completion of the audit.

_____ _____
CLIENT NAME Date

_____ _____
Signature of Parent or Legal Guardian Date

# Client Consent to Release Information To

**Inupiat Community of the Arctic Slope (ICAS)**
**Vocational Rehabilitation Program**
**PO Box 1610 Barrow, Alaska 99723**
**Phone: (907) 852-2448 Fax: (907) 852-2449**

**Client Name:**_____ **SSN:**_____-____-_____
**DOB:** _____

**Client Address:**_____

The information is to be released **From:**

**Name of**
**Facility/Person/Organization:**_____
**Address:** _____
**City/State/Zip Code:**_____
**Tel:**_____ **Fax:**_____
**Email:**_____

## AUTHORIZATION

I authorize the mutual exchange of information in person, by telephone, fax, or email, regarding myself between the above indicated parties for the express purpose of: Obtaining records that will document a disabling condition, for use in the determination of eligibility for services through the Inupiat Community of the Arctic Slope Vocational Rehabilitation Program, and for exchange of medical/education/therapeutic/ social/economic/family/legal and all other information for service plan development and ongoing vocational rehabilitation services. I have been offered a copy of this document.

**OTHER OR SPECIFIC INFORMATION (SPECIFY):**

_____

_____

_____

I understand that I may cancel this authority at any time, except to the extent that action has already been taken. Unless cancelled earlier by me, this authorization will expire ninety (180) days from the signature date or on the specified expiration date.

Client Signature Signature Date Expiration Date

Signature of Parent or Legal Guardian Signature Date Expiration Date

# Client Consent to Release Information To

**Inupiat Community of the Arctic Slope (ICAS)**
**Vocational Rehabilitation Program**
**PO Box 1610 Barrow, Alaska 99723**
**Phone: (907) 852-2448 Fax: (907) 852-2449**

**Client Name:**_____ **SSN:**_____-____-_____
**DOB:** _____

**Client Address:**_____

The information is to be released **From:**

**Name of**
**Facility/Person/Organization:**_____
**Address:** _____
**City/State/Zip Code:**_____
**Tel:**_____ **Fax:**_____
**Email:**_____

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_____

_____

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Client Signature | Signature Date | Expiration Date

Signature of Parent or Legal Guardian | Signature Date | Expiration Date