

## TVR INTAKE FORM

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Application Date: \_\_\_\_\_

Lives in service area: Yes No Verification Documentation: \_\_\_\_\_

### TRIBAL ENROLLMENT STATUS (Required):

**Tribe:** \_\_\_\_\_ **Enrollment Number:** \_\_\_\_\_

\_\_\_\_ Copy of Tribal Enrollment Card/Documentation (in file)  
\_\_\_\_ Requested from Tribe **(Release Needed)**  
\_\_\_\_ Requested from \_\_\_\_\_ **(Release Needed)**

Is their first time applying for VR Services: Yes No  
If no, when and what program \_\_\_\_\_  
Referred to <program> by: \_\_\_\_\_ Phone Number (if needed): \_\_\_\_\_

What conditions are reported to affect their ability to work: \_\_\_\_\_

How does this person believe these conditions prevent them from getting a job, keeping a job or performing the essential duties of their job?: \_\_\_\_\_

Job Title	Dates of Employment	Rate of Pay	# hrs/week	Reason for Leaving

Do they participate in cultural activities? Yes No  
If yes, explain: \_\_\_\_\_

Any assistive devices or other technology needed to return to work:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL BACKGROUND:

Are there any other conditions we should consider during the process of this case?  
\_\_\_\_ Vision/Hearing/Speech    \_\_\_\_ Head Injury/stroke    \_\_\_\_ Heart    \_\_\_\_ Asthma/Shortness of Breath  
\_\_\_\_ High blood pressure    \_\_\_\_ Chronic Pain    \_\_\_\_ Mobility    \_\_\_\_ Seizures/Convulsions

Blood Disorder       Tumor/Cancer       Insomnia       Blackouts/Fainting  
 Allergies/rashes       Stomach/intestines       Headaches       Other (please explain)

Are there problems or concerns with any of the following:

<input type="checkbox"/> Stamina/Strength	<input type="checkbox"/> Remembering things	<input type="checkbox"/> Stress
<input type="checkbox"/> Following instructions	<input type="checkbox"/> Working too slow	<input type="checkbox"/> Math
<input type="checkbox"/> Getting along with others	<input type="checkbox"/> Anxiety or panic	<input type="checkbox"/> Speech
<input type="checkbox"/> Absences from work	<input type="checkbox"/> Concentration	<input type="checkbox"/> Coordination
<input type="checkbox"/> Reading or writing	<input type="checkbox"/> Anger or short temper	<input type="checkbox"/> Depression

Medical Insurance: Medicaid    Medicare    IHS    Veteran's    Other: \_\_\_\_\_

Is there a history of Behavioral Health treatment?    Yes    No

Diagnosis: \_\_\_\_\_

Provider: \_\_\_\_\_

Is there a history of Substance Use?    Yes    No

    Currently?    Yes    No

Are you currently participating in:

12 Step Group?    Yes    No

Outpatient Counseling?    Yes    No    With whom? \_\_\_\_\_

Relapse Prevention?    Yes    No    With whom? \_\_\_\_\_

Any inpatient treatment?    Yes    No    Where/when? \_\_\_\_\_

Is there another form of treatment which is utilized to maintain sobriety? \_\_\_\_\_

Medications currently being taken \_\_\_\_\_

Use of any medically prescribed assistive aids (brace, cane, hearing aids) \_\_\_\_\_

Physicians/Specialists involved in care: **(Releases Needed)**

Name	Address	Date Last Seen
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Name	Address	Date Last Seen
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**EDUCATION BACKGROUND:**

\_\_\_\_\_ High School Diploma      \_\_\_\_\_ GED      If didn't complete, highest grade completed \_\_\_\_\_

\_\_\_\_\_ College/University      \_\_\_\_\_ Trade School      \_\_\_\_\_ Graduate school

College/Trade School	Dates Attended	Program of Study	Degree Received

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Was/Is school difficult? Yes No If yes, how? \_\_\_\_\_  
Did they have an IEP or 504 plan in school?: Yes No \_\_\_\_\_  
Do they plan to further their education? Yes No \_\_\_\_\_  
Explain \_\_\_\_\_

Do they have current certificates/licenses (i.e. first aid, CPR, Food handlers, CDL, etc.)? Yes No  
If yes, what?: \_\_\_\_\_

**MILITARY SERVICE?**

Yes No If yes, what branch? \_\_\_\_\_  
Dates of service \_\_\_\_\_ Discharge type \_\_\_\_\_

**TRANSPORTATION:**

Reliable? Yes No \_\_\_ Own \_\_\_ Public Transportation \_\_\_ Bike \_\_\_ Borrow Vehicle  
Valid Driver's License: Yes No If yes, what Number/State? \_\_\_\_\_  
\_\_\_ Revoked \_\_\_ Suspended \_\_\_ Restricted Explain: \_\_\_\_\_  
Current Insurance Yes No

**MARITAL STATUS:** \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorce \_\_\_ Partnership \_\_\_ Widowed

Dependent children or family? Yes No If yes, how many?: \_\_\_\_\_

**LIVING SITUATION**

\_\_\_ Rent \_\_\_ Own \_\_\_ Permanent \_\_\_ Temporary Stable? Yes No  
Who all lives there? \_\_\_\_\_

Are Independent Living issues evident: Yes No If yes, explain \_\_\_\_\_

**COMPARABLE SERVICES AND BENEFIT PROGRAMS: (Releases Needed)**

\_\_\_ Substance Use Disorder Program \_\_\_ Behavioral Health \_\_\_ Veteran's Program \_\_\_ Housing  
\_\_\_ Developmental Disabilities \_\_\_ Employment Security \_\_\_ Tribal WIA/NEW/GA  
\_\_\_ DSHS (TANF/GAU) \_\_\_ Social Security \_\_\_ Tribal Social Services  
\_\_\_ Labor and Industries (L&I) \_\_\_ Financial Aid \_\_\_ DVR/TVR

Receiving SSI or SSDI? Yes No

**EMERGENCY CONTACT:** \_\_\_\_\_

Name	Phone	Relationship
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Are there any restrictions on when/how we may contact this person? \_\_\_\_\_

**NEXT STEPS IN ASSESSMENT FOR ELIGIBILITY (Releases Needed):**

\_\_\_ Obtain existing medical information from: \_\_\_\_\_  
\_\_\_ Alcohol/Drug Evaluation: (when/where) \_\_\_\_\_  
\_\_\_ Psychological Evaluation: (when/where) \_\_\_\_\_  
\_\_\_ Vision Evaluation: (when/where) \_\_\_\_\_

\_\_\_ Physical Evaluation: (when/where) \_\_\_\_\_  
\_\_\_ Hearing Evaluation: (when/where) \_\_\_\_\_  
\_\_\_ Other: \_\_\_\_\_

**INFORMATION PROVIDED TO THE NEW APPLICANT:**

\_\_\_ Client Assistant Program/Brochure  
\_\_\_ VR Process Sheet  
\_\_\_ Right's and Responsibilities  
\_\_\_ Other \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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