



## COEUR D'ALENE TRIBE CAREER RENEWAL VOCATIONAL REHABILITATION PROGRAM

1120 B ST / PO BOX 408 PLUMMER, ID 83851  
PHONE (208) 686-2084 FAX (208) 686-2059

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### **Documentation Needed List**

Here is a list of the supporting documents and items that you will need to complete your application. Please bring these items with you when you come to the Coeur D'Alene Tribal Career Renewal office. Please try to have all things on the list as this will help speed up the application process and get services provided to qualifying applicants.

- Your Tribal ID card
- State Driver's License or State ID card
- A work history as complete as possible (Found in this application)
- A list of any prescription medications you are taking
- The name and address of medical or mental health providers, past and present
- Proof of residency in our service area, for example; utility bill in your name, or a letter from the person you reside with
- A list of or copies of any income you are receiving, for example; check stubs or earning statements

# COEUR D'ALENE TRIBE VOCATIONAL REHABILITATION

Career Renewal Program

APPLICANT INFORMATION										
Last Name		First		M.I.	Date					
Street Address					Apartment/Unit #					
City				State			ZIP			
Phone				Cell Phone:			Email Address:			
Mailing Address				City			State	Zip		
Date of Birth	Are you currently utilizing ANY OTHER TRIBAL PROGRAMS (TANF/LIHEAP/DEPT. OF ED./ETC.)? Y N									
Gender	F <input type="checkbox"/>	M <input type="checkbox"/>	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>							
U.S. Military	YES <input type="checkbox"/>	NO <input type="checkbox"/>	TRIBE:	ENROLLMENT #:		SSN#				
<b>EMERGENCY CONTACT</b>										
Name: _____ Relationship: _____ Number: (    ) _____										
<b>CONTACT PERSON NOT LIVING IN YOUR HOME</b>										
Name: _____ Relationship: _____ Number: (    ) _____										
What is your primary (largest) source of support? Check one of the following:										
<input type="checkbox"/> Your personal Income (earnings, interests, dividends, rent) <input type="checkbox"/> Your spouse's income, or support from family and friends <input type="checkbox"/> Public support such as SSDI, SSI, TANF, etc. <input type="checkbox"/> Other: _____										
Please check one of the following which best describes your current living arrangement:										
<input type="checkbox"/> Private residence (On your own, with family or roommate) <input type="checkbox"/> Medical Facility <input type="checkbox"/> School/Other Institution <input type="checkbox"/> Community Residential Group Home <input type="checkbox"/> Correctional Institution <input type="checkbox"/> Homeless/Shelter										
Please Describe Your Disability (You must have a disability in order to be eligible for our program):										
Other information you would like to make us aware of (please list any current probation/court) :										
Applicant Signature: _____ Date: _____										
Received By: _____ Date: _____										



**Coeur d'Alene Tribe Career Renewal Vocational  
Rehabilitation Program  
1120 "B" Street  
P.O. Box 408  
Plummer, ID. 83851**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**BY SIGNING THE FOLLOWING DOCUMENT, I AUTHORIZE THE COEUR D'ALENE TRIBE CAREER RENEWAL VOCATIONAL REHABILITATION PROGRAM TO EXCHANGE CONFIDENTIAL INFORMATION WITH ANY OF THE FOLLOWING PROGRAMS:**

- |  |   |
|--|---|
| <input type="checkbox"/> Social Security Administration              | <input type="checkbox"/> Health and Human Services – Tribal and State |
| <input type="checkbox"/> Marimn Health – Counseling and Medical      | <input type="checkbox"/> Marimn Health - Purchased and Referred Care  |
| <input type="checkbox"/> Attorney or legal representatives           | <input type="checkbox"/> Probation and Parole                         |
| <input type="checkbox"/> Tribal or State Child Support               | <input type="checkbox"/> Indian Child Welfare                         |
| <input type="checkbox"/> STOP Violence Against Indian Women          | <input type="checkbox"/> Coeur d'Alene Tribe Reentry Program          |
| <input type="checkbox"/> Coeur d'Alene Tribe Department of Education | <input type="checkbox"/> Coeur d'Alene Tribal Housing                 |
| <input type="checkbox"/> Native Employment Works                     | <input type="checkbox"/> TANF   |
| <input type="checkbox"/> Current employer                            | <input type="checkbox"/> Tribal and State Voc. Rehab. Programs        |
| <input type="checkbox"/> Other: _____                                |   |

Records on (Name): \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDICAL RECORDS PERTAINING TO MY MENTAL OR PHYSICAL DISABILITY**

Records needed: Documentation of Disability – please circle all that apply

**Mental Health Diagnosis                      Medications                      GAIN assessment                      Physical Health Records**

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke or withdraw this authorization by notifying CDA Tribe Career Renewal Voc. Rehab. in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I further understand, that the services provided to me by the Coeur d'Alene Tribe Career Renewal Voc. Rehab. Program is a **privilege** not an inherent right. **Failing to sign this document could result in a limited amount of services or benefits, and/or the disqualification of my application.** In order to better serve you, the CDA Tribe Career Renewal Voc. Rehab. Program must have the capabilities to share information with other programs and agencies, at the Tribal, Federal and State Levels.

With my signature, I understand that any information obtained may be released and shared with the proper tribal, federal or state government agency, court or law enforcement for the purpose of legal and investigative action concerning fraud.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of CDA Tribal Social Services Agent or Representative: \_\_\_\_\_



**CAREER RENEWAL PROGRAM  
FINANCIAL NEEDS ASSESSMENT**

Client Name: \_\_\_\_\_ IPE#: \_\_\_\_\_

IPE Beginning Date: \_\_\_\_\_ IPE Ending Date: \_\_\_\_\_

Monthly Income: (Please include take-home (Net) pay from a job, SSI, SSDI, TANF, TAFI, VA, UI, WC, retirement, private disability, child support, etc.)

Monthly Expenses:

Rent or House Payment	\$ _____ per mth
Utilities (subtract energy assistance):	\$ _____ per mth
Food	\$ _____ per mth
Vehicle payment:	\$ _____ per mth
Fuel for vehicle:	\$ _____ per mth
Insurance:	\$ _____ per mth
Medical Expenses (medications/bills):	\$ _____ per mth
Clothing (for self and dependants):	\$ _____ per mth
Child support:	\$ _____ per mth
Credit Cards (minimum monthly payments combined):	\$ _____ per mth
Other Cost (Misc)	\$ _____ per mth
Total Monthly Expenses:	\$ _____

Total Monthly Income \$ \_\_\_\_\_ Total Monthly Expenses: \$ \_\_\_\_\_

Total Monthly Budget Surplus (left over per month) \_\_\_\_\_

I certify that this financial information is accurate.

Client: \_\_\_\_\_ Date: \_\_\_\_\_ Guardian \_\_\_\_\_

CRP Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Approved Expenditures \$ \_\_\_\_\_ Date Approved: \_\_\_\_\_

Total Monthly Budget Surplus \$ \_\_\_\_\_



**COEUR D'ALENE TRIBE  
CAREER RENEWAL PROGRAM  
1120 B STREET  
PLUMMER, IDAHO  
208 686-6802**



**COEUR D'ALENE TRIBE VOCATIONAL REHABILITATION PROGRAM  
CONSUMER RIGHTS & RESPONSIBILITIES**

**YOUR CAREER RENEWAL COUNSELOR'S RESPONSIBILITIES:**

1. To work with you to identify your specific health and supportive services needs.
2. To provide ongoing counseling and guidance, as well as follow-up services working toward the definition of a specific employment goal in tune with your abilities, capabilities, strengths and informed choice.  
To meet with you regularly to make sure that progress is being made toward the definition of an Employment Goal.
3. To work with you in a professional and ethical manner consistent with the policies of the Career Renewal (Vocational Rehabilitation) Program.

**YOUR RESPONSIBILITIES AS A PARTICIPANT:**

1. To make all reasonable efforts to define a vocational goal.
2. To maintain satisfactory progress as agreed upon with your CPR counselor.
3. To maintain contact with your CRP counselor and to report progress as well as changes of name, address, and change in financial and/or living circumstances.
4. To keep all appointments with your CRP counselor and other scheduled appointments.
5. To cooperate and follow through with medical and other professional instructions.
6. To use all comparable services and benefits, including student financial aid and Tribal health services as development of your employment plan is being defined.
7. To notify your CRP counselor if and when employed and provide details of your employment.
8. To participate in periodic reviews of your file, as needed/requested by your CRP Counselor.

**YOUR RIGHTS AS A PARTICIPANT:**

1. You are to be fully consulted regarding any updates to your file as appropriate.
2. You may discuss a problem or grievance with the CRP or the CRP's supervisor at any time.
3. If at any time you are dissatisfied with any decision made by the staff of the Coeur d'Alene Tribe CRP Program, you have the right to a Fair and Impartial Hearing (see Grievance form).
4. You may contact the Client Assistance Program (CAP) at any time during your CRP process. Their number is 1-866-262-3462. The CAP is available to answer questions you may have regarding your involvement with the Coeur d'Alene Tribe Vocational Rehabilitation Program.
5. You are to be provided the opportunity to participate in an annual review of any ineligibility decision.
6. Title VI of the Civil Rights Act of 1964 and Tribal policy prohibit discrimination based on the grounds of disability, religion, gender, age, race, color, creed or national origin.
7. All information obtained through your involvement with the Coeur d'Alene Tribe CRP Program is voluntary and is necessary to accomplish your rehabilitation and employment and will be kept confidential. Information will be released only with your permission, pursuant to Tribal Policy.

\_\_\_\_\_  
Consumer Signature or Authorization Representative

\_\_\_\_\_  
Date

**Work History**

Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Starting Salary:\$ \_\_\_\_\_ Ending Salary:\$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Starting Salary:\$ \_\_\_\_\_ Ending Salary:\$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Starting Salary:\$ \_\_\_\_\_ Ending Salary:\$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Starting Salary:\$ \_\_\_\_\_ Ending Salary:\$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_



## Coeur d'Alene Tribe Career Renewal Vocational Rehabilitation Program

A Vocational Rehabilitation Program  
1120 B St. P.O. Box 408 Plummer, Id 38351  
Phone: (208) 686-2084 Fax: (208) 686-2059

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### Substance Abuse Agreement

Full Name: \_\_\_\_\_

Please read the following statement, sign and date below. Your signature indicates that you understand and agree to abide by these terms and conditions.

While receiving services from the Coeur D'Alene Tribe's Voc. Rehabilitation Program you are required to maintain **TOTAL ABSTINENCE** from the following: Drugs, illegal substances, and abuse of prescription drugs, all of which can be mood altering or debilitating.

If at any time staff of the Voc. Rehab Program observes or receives proof demonstrating your use of any of the substances listed, all services being provided to you will be **TERMINATED IMMEDIATELY**.

If you do not agree and claim you are not actively using, you will have the option of submitting a U.A. which may be administered by your Voc. Rehab counselor upon request. We will also accept confirmation from your drug and alcohol counselor stating you are not actively using.

Your services may be reinstated after you have completed the following:

- (1) Enter and successfully complete an alcohol/substance abuse program (21 days or longer) and follow all recommendations made by the treatment facility.
- (2) Provide a letter from your drug and alcohol counselor stating you have abstained from all substances for at least 60 consecutive days.

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My signature below indicates that I have read and understand the above statement and agree to comply with the terms. If I fail to adhere to these terms my status as a Coeur D'Alene Tribe Career Renewal Vocational Rehabilitation consumer may be terminated.

Consumer signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor signature \_\_\_\_\_ Date \_\_\_\_\_

## ADVERSE CHILDHOOD EXPERIENCE (ACE) QUESTIONNAIRE/SURVEY

**\*Note:** For CDA Tribal members.

Please do not put your name on this survey, Tribal ID ok here \_\_\_\_\_.

**Prior to your 18<sup>th</sup> birthday did you experience:**

- |   |         |
|---|---------|
| 1. Did a parent or other adult in the household often:<br>Swear at you, insult you, put you down, humiliate you or threaten<br>you with physical harm?                                | Y__ N__ |
| 2. Did a parent or other adult in the household often....<br>physically hurt you, slap, grab, punch you & left marks on you?  | Y__ N__ |
| 3. Did an adult or person at least 5 yrs. older than you ever....<br>touch or fondle you or make you do anything sexual to them or<br>actually perform sex act with you?              | Y__ N__ |
| 4. Did you often feel that....<br>Unloved or unimportant in your family OR<br>Your family was not close and unsupportive of one another   | Y__ N__ |
| 5. Did you often feel that....<br>You didn't get enough to eat, had to wear dirty clothes OR<br>Unprotected by parent because they were too drunk or too high<br>to take care of you? | Y__ N__ |
| 6. Was there domestic violence or threats of gun in your home?  | Y__ N__ |
| 7. Did you suffer loss of a parent or close family member?  | Y__ N__ |
| 8. Was there a family member in your household who had alcohol<br>and/or drug addictions?   | Y__ N__ |
| 9. Was a household member depressed, mentally ill or anyone attempt<br>suicide in your household?   | Y__ N__ |
| 10. Did anyone in your household go to jail or prison?  | Y__ N__ |

Instructions: Enter a "1" for each yes checked and tally the total number here \_\_\_\_\_