



Lac Courte Oreilles **VOCATIONAL REHABILITATION**

The Lac Courte Oreilles Vocational Rehabilitation Services Program offers *employment* services to Native Americans with disabilities to assist in obtaining, maintaining or improving employment.

Eligibility is based on the following criteria:

- Must be a member of a federally or state recognized American Indian Tribe;
- Must reside on the LCO reservation or within Sawyer County;
- Must have a physical or mental impairment (disability) which constitutes or results in a substantial impediment to employment
- Be able to benefit in terms of an employment outcome from VR services and require VR services to prepare to enter, engage in, or retain gainful employment

The following documents are required with the application:

- Drivers License or State ID
- Tribal ID
- Verification of residency (physical address)
- If you receive Social Security Disability benefits (SSI or SSDI) because of your disability, you are presumed eligible for LCOVR services. Please provide documentation of benefits.

Upon receipt of a COMPLETE application for services, the LCO VR staff will:

- Schedule and conduct an intake interview to assist in determining eligibility and appropriate services.
- Request copies of medical records verifying your disability, or the VR counselor will obtain your signature on appropriate information release forms permitting your physician and/or others to provide this information.
- After all required documentation is provided, LCOVR has 60 days to make an eligibility determination and will provide notification of decision by mail.

Once you are determined eligible under the program's guidelines, you will enter into the rehabilitation phase of your program and begin the development of an Individual Plan for Employment. *LCOVR will work to assist and guide you with your goals, but you will have responsibilities as the key person in achieving success in your goals.*

**LCO VOCATIONAL REHABILITATION SERVICES
PROGRAM APPLICATION**

Date:	DOB:	
Name:	SS#:	
Street Address:		
Mailing Address:		
City:	State:	Zip:
Phone:	Message:	
County of residence:		
E-Mail Address:		
Tribal Affiliation:	Tribal ID#:	

Have you ever received any services from a tribal or state vocational rehabilitation agency? <input type="checkbox"/> YES <input type="checkbox"/> NO

Do you have a valid driver's license? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, which state? _____ DL# _____
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Do you have a physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please list disability:</i> _____
Do you have a mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please list disability:</i> _____
Is the disability a result of a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of the accident: _____ Name of employer: _____
Are you having problems finding or keeping jobs? <input type="checkbox"/> Yes <input type="checkbox"/> No Are those problems because of your disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain how your disability affects your ability to obtain or maintain employment: _____

Are you currently employed? If yes, employer's name: _____ Current hours/week: _____ Weekly earnings: \$ _____ How long have you been employed here? _____

If not employed, how long have you been unemployed? _____

EDUCATION HISTORY

Are you currently a high school student? Yes No
If yes, what is the name of the school: _____ Grade level: _____
Highest grade completed: _____ Date diploma received? _____
Did you receive a GED? Yes No If yes, date received: _____

EMPLOYMENT HISTORY

Employer:	Job Title:	
Start Date:	End Date:	Hours/Week:
Duties:	Earning/Week:	
Reason for Leaving:		

Employer:	Job Title:	
Start Date:	End Date:	Hours/Week:
Duties:	Earning/Week:	
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Employer:	Job Title:	
Start Date:	End Date:	Hours/Week:
Duties:	Earning/Week:	
Reason for Leaving:		

MEDICAL CLINICS AND PHYSICIANS

Physicians Name:	Name of Clinic:
Address:	
Phone #:	

Physicians Name:	Name of Clinic:
Address:	
Phone #:	

CONSUMER SIGNATURE

DATE

GUARDIAN SIGNATURE (IF CONSUMER IS UNDER THE AGE OF 18)

DATE

Office Use Only. Application Received By: _____ Date: _____
 Orientation Video Tribal ID Dr. License/State ID Physical address verification rev11.10u

FUNCTIONAL LIMITATIONS CHECKLIST

NAME: _____ DATE: _____

The following checklist was developed to assist in determining whether or not you may be eligible for LCO Vocational Rehabilitation services. This will help to provide additional information regarding your disability or impairments. Please answer “YES” or “NO” to the following questions:

MOBILITY:

- YES NO Are you limited in speed or distance for walking?
- YES NO Do you need the use of, or assistance from another person, brace, cane, crutch, prosthetic device, wheelchair or other assistive device to walk?
- YES NO Do you have a physical impairment that affects your travel around the community?
- YES NO Do you require mobility training or help from others to get around the community?
- YES NO Do you need help to get around the inside of your home or work site, including stairs and entering/exiting the building?

COMMENTS:

COMMUNICATION:

- YES NO Is your main means of communication other than speech?
- YES NO Is your speech difficult for others to understand?
- YES NO Do you depend on lip reading?
- YES NO Do you communicate primarily through the use of Sign Language?
- YES NO Do you have difficulty explaining your wants and needs?
- YES NO Do you have difficulty with the English language? In reading or writing?

COMMENTS:

SELF-CARE:

- YES NO Do you have difficulty with activities of daily living getting ready for work?
- YES NO Does it take a long time to get ready to go to work?
- YES NO Do you need assistance to take care of toileting and personal care tasks?
- YES NO Do you need to follow strict dietary requirements?
- YES NO Do you feel that your personal dress and hygiene are adequate for most jobs?
- YES NO Do other people (friends, family or health care professionals) criticize your personal dress and hygiene?

COMMENTS:

SELF-DIRECTION:

- YES NO Have friends, family or health care professionals criticized your decisions?
- YES NO Do you need assistance in making decisions in your everyday life?
- YES NO Do you take medications that negatively impact focus or decision-making?
- YES NO Have you ever been hospitalized in order to prevent you from harming yourself or others?
- YES NO Have you ever harmed yourself or others?
- YES NO Have you ever been arrested, convicted, jailed, been on probation/parole?
- YES NO Do you have problems understanding your strengths, limitations and preferences?
- YES NO Do you have a hard time telling others why you need vocational assistance?

COMMENTS:

INTERPERSONAL SKILLS:

- YES NO Do you feel uncomfortable around others?
- YES NO Do you feel disconnected from other people?
- YES NO Do you have difficulty with establishing meaningful relationships with anyone?

- YES NO Do you become angry easily, or without the appropriate justification?
- YES NO Do you display behaviors in public that others have difficulty accepting?
- YES NO Do you feel overly defensive when others criticize your behavior or actions?

COMMENTS:

WORK TOLERANCE:

- YES NO Do you have any standing, walking, bending, lifting or carrying restrictions? If yes, please indicate any **formal** work restrictions from your doctor.
- YES NO Do you need a job where you can sit most of the time?
- YES NO Do you need a job that will let you have frequent rest periods?
- YES NO Do you need a job that will let you change positions frequently?
- YES NO Do you feel that you can work full-time?
- YES NO Does your disability require a flexible work schedule?

COMMENTS:

WORK SKILLS:

- YES NO Do you lack work skills that would help you to get a job?
- YES NO Have you ever been fired from a job?
- YES NO Have you been unemployed for the last three years?
- YES NO Have you held a job for at least six months in the last three years?
- YES NO Does your disability prevent you from using your work skills or training?
- YES NO Do you feel your work skills have deteriorated due to extended unemployment, because of your disability?

COMMENTS: