FALLON PAIUTE-SHOSHONE TRIBE
VOCATIONAL REHABILITATION PROGRAM

1007 Rio Vista Drive
Fallon, Nevada 89406-5463
Telephone: (775) 428-2250
Fax: (775) 423-8960
M-F 8am-5pm
vrmanager@fpst.org

To apply for Voc Rehab, please provide the following to our office:

1. _____ Proof of Tribal Enrollment:
   - Tribal ID or
   - CIB (Certificate of Indian Blood)

2. _____ Identification:
   - Valid Driver's License or Nevada I.D. Card, school ID and;
   - Social Security Card

3. _____ Current proof of residency.

4. _____ Voc Rehab application *signed by applicant*.

The documents can be emailed, faxed, mailed or walked into the Voc Rehab Office. The next step is for a VR Counselor to go over your application with you.

If you need assistance in filling out the application or do not have the required documents, please let us know and we can assist you.

VR Staff Initials & Date: _____

FALLON PAIUTE-SHOSHONE TRIBE

VOCATIONAL REHABILITATION PROGRAM

"CROSSING RAINBOWS - PATHWAYS TO SUCCESS"

APPLICATION FOR SERVICES

(Office Use Only)
Case ID #: _____

1007 Rio Vista Drive
Fallon, Nevada 89406
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"Crossing Rainbows - Pathways to Success" Vocational Rehabilitation Program offers vocational services to individuals who meet the following requirements:

- Must be an enrolled member of a federally recognized Native American Tribe and/or Alaska Native.
- Must reside within the boundaries of Churchill, Nye or Pershing County.
- Must have a Physical or Mental Health impairment that is documented by a Medical or other Licensed Provider.

Contact Information: (Proof Required: 2 Valid ID's, Current residential verification)

Date: _____ Email address: _____

Name: _____
Last First M.I. Maiden

Other Name(s) Used: _____

Residence/Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone: Home: _____ Work: _____ Cell: _____

Contact Person Name: _____ Phone: _____

Contact Person Address: _____

Personal Information: (Proof Required: Social Security Card, Tribal ID)

SSN: _____-_____-_____ Birthdate: _____ Age: _____ Gender: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ] Never Married

[ ] Alaska Native [ ] Native American. Tribal Affiliation: _____ Enrollment #: _____

Driver's License/State ID #: _____ Issuing State: _____

I was referred by: _____ Department: _____

Were you ever involved with the legal system (Court, jail, detention, probation, etc.) ? [ ] Yes [ ] No

If yes, please explain: _____

Have you ever been convicted of a felony? [ ] Yes [ ] No

This policy shall remain in effect until superseded or rescinded by the Fallon Business Council

Drafted: 2/26/2020 Approved: 6/23/2020 Effective: 7/6/2020 ERB

Name: _____

Disability/Health Information: (Required: Letter of Disability, Medical/Behavioral documentation)

Have you been seen by a Medical Provider or other Licensed Provider for your disability? [ ] Yes [ ] No

What is your disability, and how does it limit your ability to work? _____

_____

_____

_____

Are you using any kind of brace or medical device? If yes, please explain. _____

_____

Have you been seen by a Doctor for the problems resulting from your disability? [ ] Yes [ ] No

_____

(Doctor's Name) (Doctor's Telephone Number)

_____

(Doctor's Address)

Please list dates you were seen by a Medical Provider or other Licensed Provider:

Dates	Reason
_____	_____
_____	_____
_____	_____

If needed, please attach an additional sheet with your information. Thank you.

Is your disability the result of a work related accident? [ ] Yes [ ] No If yes, list the date of accident **and** name and address of the employer _____

_____

List Medication(s) that you are currently taking: _____

_____

_____

Do you have Private Medical/Hospital Insurance, Medicare and/or Medicaid? If Yes, please list type, company name, address, and policy/groups or case number: _____

_____

_____

Supplemental Security Income (SSI) Status: _____

Social Security Disability (SSDI) Status: _____

Are you currently working with other agencies regarding your disability? [ ] Yes [ ] No, if Yes, please list:

_____

_____

_____

_____

Drafted: 2/26/2020 Approved: 6/23/2020 Effective: 7/6/2020 ERB

Name: _____

Educational Information:

Highest grade completed: _____ G.E.D.? [ ] Yes [ ] No If Yes, date received: _____

Educational Background: (List the school/trainings you have attended)

School	Course/Major	Diploma/Certificate Rcvd.	Month/Year Completed

Military Service Information:

Veteran: [ ] Yes [ ] No Military Branch: _____ Dates of Service: _____

Rank: _____ Discharge (DD-214) : Honorable [ ] Dishonorable [ ]

On Disability? [ ] Yes [ ] No Specific Details: _____

Household Information: (Please attach an additional sheet if needed)

Current Residence Address: _____

Number of people living in your house: _____ How many are dependents? _____

Name	Age	Relationship	Employed/Where	Weekly Net Salary
		Self		

Employment Information:

Employment status during the past week:

[ ] Competitive labor market [ ] Not working/student [ ] Sheltered workshop
[ ] Not working/other [ ] Self-employed [ ] Trainee
[ ] Small business enterprise [ ] Homemaker [ ] Unpaid family worker

If you are currently employed, weekly earnings: $ _____ Number of hours per week: _____

What assistance are you asking from the FPST Vocational Rehabilitation Program: (work related) _____

_____

_____

Name: _____

Employment History: Begin with your most recent job and include the job you had for the longest period of time. If you have a resume, please bring it in to include in your file.

Job Title:	Dates of Employment:	Salary:
Employer:	Employer Address:	
Duties:		
Reason for Leaving:		
Does your disability keep you from returning to this type of job?		

Job Title:	Dates of Employment:	Salary:
Employer:	Employer Address:	
Duties:		
Reason for Leaving:		
Does your disability keep you from returning to this type of job?		

Job Title:	Dates of Employment:	Salary:
Employer:	Employer Address:	
Duties:		
Reason for Leaving:		
Does your disability keep you from returning to this type of job?		

What type of career are you interested in?

Name: _____

Release of Verification:

By signing this application, I am requesting services from the Fallon Paiute-Shoshone Tribe Vocational Rehabilitation Program. I further certify that the information provided herein is correct/accurate. I understand that the FPSTVRP may use my name and Social Security number to verify with the Social Security Administration the status of any Social Security Benefits I may be receiving.

Residence Certification:

In accordance with Section 121 (a) of the Vocational Rehabilitation Act of 1973 (amended 1998), I affirm that I live on or near the Fallon Paiute-Shoshone Tribe, or the Lovelock Paiute Tribe, or the Yomba Shoshone Tribe. I have submitted the appropriate documentation verifying my residency located on or near one of the Tribes listed above.

Confidentiality Statement:

By signing this application, I understand that all submitted information will be held in confidentiality. I have been informed of the process to file a complaint should I believe such confidentiality has been breached.

_____ _____ _____

Print Your Name | Your Signature | Date

_____ _____

VR Counselor Signature | Date