Kawerak Vocational Rehabilitation (KVR)

Application Packet Instructions

What We Do: The Kawerak Vocational Rehabilitation Program helps people with disabilities in the following ways: 1) obtain a job, 2) keep a job, 3) get back into subsistence activities, 4) keep subsistence activities going, 5) start a business, 6) keep a business going.

Are you Eligible? In order to be eligible for the KVR Program you must:

1) Be 16 years of age or older.
2) Have a documented physical and/or mental impairment that creates a substantial barrier to your ability to do any one of the activities listed above.
3) Be a resident of the Bering Strait Region.
4) Be tribally enrolled to a federally recognized tribe.
5) Be in a situation where you are able to benefit from the KVR Program's vocational rehabilitation services.

☺ *We need your general information.* Please complete the Kawerak Education, Employment and Training Division VR Application. ***(Page 1)***

☺ *We need to know where you are tribally enrolled.* Please provide a copy of your tribal enrollment ***or*** sign the Authorization for the Release of Tribal Enrollment Verification. ***(Page 2)***

☺ *We need to know what learning problems, physical health, and/or mental health problems keep you from working, subsisting, or starting a business.* Please sign the Norton Sound Health Corporation (NSHC) Authorization for Use and Disclosure of Health Information ***if*** your records are there. ***(Page 3)***

☺ *You need to know what your rights and responsibilities are if you are found to be eligible for this program.* Please sign the Kawerak Vocational Rehabilitation Consumer Rights and Responsibilities Form ***(Page 4)***

☺ To determine your eligibility and make a plan with you, we need to know how your disability makes it hard for you to be self-sufficient. Please complete the disability questionnaire. ***(Page 5)***

*Please Note:

1) All signatures must be in ink, not pencil.
2) Please keep the rest of the forms included in this packet for your records.
3) Please return completed pages 1, 2, 3, and 4, to:

Kawerak, Inc. Vocational Rehabilitation Program
P.O. Box 948
Nome, AK 99762

4) Once we get your application we will send you the appropriate releases of information. Your application will not be complete until we get the corresponding records needed to determine your eligibility.

For questions please call...
Toll Free at 1-877-759-4362 or Direct at 443-4362

Mailing Address: P.O. Box 948 Nome, AK 99762 ~ **Phone**: (907) 443-4362 ~ **Toll Free**: 1-877-759-4362 ~ **Fax**: (907) 443-4475

Applicant's Information

Name: _____ / _____ Current Age _____
(First) (Middle) (Last) (Nic Name *or* Maiden Name)

Social Security Number: ___-___-___ Date of Birth: ___/___/___ Gender: ☐ Male ☐ Female

Mailing Address: _____ _____ _____ _____
(P.O. Box) (City) (State) (Zip Code)

Physical Address: _____ _____ _____ _____
(Street Address if Known) (City) (State) (Zip Code)

Home Phone: (___)___-___ Work / Alternate Phone: (___)___-___ Email: _____

Veteran? ☐ No ☐ Yes - Date of Discharge: ___/___/___ **Registered with Selective Service?** ☐ Yes ☐ No ☐ N/A

Educational Status: ☐ High School Diploma -Year Graduated: _____ *or* ☐ GED - Year obtained _____ *or* Highest Grade Completed: _____ ☐ College/Vocational Graduate - Type of Degree: ☐ AA/AAS ☐ BA/BS ☐ MA/MS

☐ Other: _____ Year _____ Most jobs are subject to drug testing. **Are you willing to take a drug test?** ☐ Yes ☐ No

Goal(s) (Check All That Apply)

- ☐ Enter Postsecondary Education or Job Training
- ☐ Obtain or Advance in a Job
- ☐ Retain Current Job
- ☐ Earn a H.S. Diploma, GED or College Diploma
- ☐ Participate in Subsistence Activities
- ☐ Start a Business
- ☐ Other: _____

I expect to meet this goal by: ___/___/___

Record of Impairment (Check All That Apply)

You may be eligible for the KVR Program if you have a physical and/or mental impairment that creates a substantial barrier to employment. Records of the impairment(s) are required before we can determine your eligibility for the program.

A record of my impairment(s) exist at the following locations:

- ☐ Alaska Native Medical Center
- ☐ Norton Sound Health Corporation
- ☐ Norton Sound Behavioral Health Services
- ☐ Bering Straits School District
- ☐ Nome Public School District
- ☐ Other: _____

Applicant's Current Status

Applicant Primary Status *(Check All That Apply)*

- ☐ Employed →
- ☐ Collecting Unemployment
- ☐ Unemployed →
- ☐ Volunteering
- ☐ Student
- ☐ Receiving SSI or SSDI
- ☐ On Public Assistance (i.e. Food Stamps, Welfare Assistance, ATAP)

Hourly Wage: $_____

Unemployed Since: ___/___/___

Tribally Enrolled At... *(Check One or write in "Other")*

- ☐ Brevig
- ☐ Council
- ☐ Diomede
- ☐ Elim
- ☐ Gambell
- ☐ Golovin
- ☐ King Island
- ☐ Koyuk
- ☐ Mary's Igloo
- ☐ Nome Eskimo
- ☐ Saint Michael
- ☐ Savoonga
- ☐ Shaktoolik
- ☐ Shishmaref
- ☐ Solomon
- ☐ Stebbins
- ☐ Teller
- ☐ Unalakleet
- ☐ Wales
- ☐ White Mountain
- ☐ Other: _____

Institutional Programs *(Check All That Apply)*

- ☐ In Correctional Facility (AMCC, etc.) Release date _____
- ☐ In Community Corrections (Seaside, etc.) Release date _____
- ☐ In Other Institutional Settings (A.P.I., Treatment Facility, etc.) Release date _____
- ☐ None of the above

I certify that the information given on this application is true to the best of my knowledge. By signing my name, I agree to allow information from this form to be used for eligibility purposes. I understand that my name will never be used in any report without written permission from me and that all data and records will be kept strictly confidential.

Signature: _____ **Signature Date:** _____

Legal Guardian's Signature: _____ **Signature Date:** _____

Kawerak Inc. Vocational Rehabilitation
P.O. Box 948, Nome, AK 99762
Phone: (907) 443-4362 or Toll Free: 1-877-759-4362
Fax: (907) 443-4475
Website: http://www.kawerak.org/vocrehab.html

Kawerak, Inc. Vocational Rehabilitation (KVR) Program Authorization for the Release of Tribal Enrollment Verification

I, _____ do hereby authorize the
(Printed Name)
release of my tribal enrollment verification to the Kawerak Vocational Rehabilitation Program for eligibility determination purposes. To my knowledge, I am tribally enrolled with _____. I understand
(Name of Tribe)
that the tribal enrollment documentation will be kept confidential at all times and that the KVR Program can only serve Alaska Natives and Native Americans who are eligible for tribal enrollment *or* have already been tribally enrolled.

_____
Date of Birth

_____ _____
Signature Date

NSHC Authorization to Use and Disclose Health Information

Patient

Patient Name: _____ (Patient)

Birth Date: _____ Ph. #: _____ Medical Record #: _____

From

I authorize Norton Sound Health Corporation (NSHC) to disclose Patient's health information as described below.

To

Health information is to be disclosed to and received and used by:

Kawerak, Inc. Vocational Rehabilitation (KVR) Program

KVR Case Manager's Fax #: (907) 443-4465 *P.O. Box 948*

KVR Program Director's Fax #: (907) 443-4475 *Nome, AK 99762*

(name/address of recipient)

Purpose

For the purpose(s) of:

☐ At my request

☑ Other purposes (specify each purpose): ***KVR Program eligibility determination purposes...***

Information to be Disclosed

Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and verbal information: *(check all that apply)*

- ☐ Discharge summaries
- ☐ History & physical exams
- ☐ Consultations
- ☐ Operative reports
- ☐ Physician progress notes
- ☐ Nursing notes
- ☐ Medication records
- ☐ Pathology reports
- ☐ Radiology & imaging reports
- ☐ Laboratory reports
- ☐ EKG Reports
- ☐ Emergency Dept. records
- ☐ Billing statements
- ☐ Clinic or office notes

Specially Protected Information about:
(must be checked to be disclosed):

- ☐ **Mental health treatment**
- ☐ **Drug/alcohol abuse diagnosis, treatment, & referral**
- ☐ **HIV / AIDS Information**

☐ Records for the following dates or treatment: _____

☐ Other information (specify): _____

All health records from NSHC (Excludes the above Specially Protected Information unless box(es) checked.)

Notices

1. There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

3. I may revoke this authorization at any time by notifying, in writing, the Director of Health Information Management of NSHC; however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization.

4. I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization is valid for the following time period:

Beginning date: _____ Ending (expiration) date: _____

Signature

SIGNATURE: I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I willingly am signing this authorization.

_____ _____

Signature of Patient or legal/personal representative Date

If not signed by Patient, Authority to sign on behalf of Patient:

_____

Kawerak Vocational Rehabilitation
Consumer Rights and Responsibilities

Your Rights

- To participate fully in the development of your own Individualized Plan for Employment (IPE).
- To be treated with dignity.
- To have your eligibility for services determined within 60 days, unless there are unforeseen circumstances and you agree to extend the time.
- To receive a fair and complete evaluation to determine your eligibility.
- To have your records and communication kept confidential. Information will not be released without your written permission, unless under court order.
- To make informed choices during the time you are enrolled in the Kawerak Vocational Rehabilitation Program.
- To appeal the Vocational Rehabilitation decisions through an Informal Review, Mediation, or formal Hearing if necessary.
- To have access to the Client Assistance Program for problem resolution. (CAP – Counselor)
- To access and receive services in a barrier free environment, including communication access and written information in an alternate format.
- To receive appropriate Assistive Technology assessments that lead to employment.

Your Responsibilities

- To take an active role in the development, implementation and completion of your IPE.
- To request disability related accommodations you require.
- To apply for and secure sources of funding for which you may be eligible for such as financial aid (Pell Grant, scholarships), insurance benefits, etc.
- To actively participate and maintain regular contact with your rehabilitation counselor.
- To talk with your counselor if you are having a problem that is affecting your vocational plan.
- To actively seek and gain employment.

I have reviewed the above consumer rights and responsibilities. My counselor has answered all questions I have about my rights and responsibilities, 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.

Participant Signature _____ Date _____

Kawerak, Inc. Vocational Rehabilitation Program
P.O. Box 948, Nome, AK 99762
Phone: (907) 443-4362 ♦ Fax: (907) 443-4475
Toll Free: 1-877-759-4362 ♦ Website: www.kawerak.org

Dear Applicant,

In order for the KVR Program to determine your eligibility and make an Individualized Plan for Employment with you we will need to know the following:

1. These are the disabilities that I have…

   ☐ Physical (List): _____

   _____

   ☐ Mental (List): _____

   _____

   ☐ Learning (List): _____

   _____

   ☐ Chemical Dependency Recovery (List): _____

   _____

2. I would like to participate in the following activities, but the disabilities that I listed above make it hard for me to: (Check All That Apply)

   ☐ Obtain a job.
   ☐ Keep a job.
   ☐ Get back into subsistence activities.
   ☐ Keep subsistence activities going.
   ☐ Start a business.
   ☐ Keep a business going.

3. This is how my disabilities make it difficult for me to become self-sufficient.

   _____

   _____

   _____

Kawerak Inc. Tribal Vocational Rehabilitation (KVR)

CONSUMER SATISFACTION

Kawerak Vocational Rehabilitation staff are committed to providing professional quality assistance and support to individuals with disabilities in efforts to attain vocational goals.

Consumers are assured that their confidentiality will be maintained in all matters, and a HIPPA Compliant Authorization for the Exchange of Protected Information will be signed before any information is released to a third party.

If a consumer believes there is a problem with services received through the KVR Program, the consumer is to report this so that the KVR Program can address the needs of the individual, and investigate the problem to determine ways to improve services for all consumers. All consumer complaints will be investigated as objectively and fairly as possible by seeking information on the issue from providers, consumer records, and other sources. All investigations will be maintained as confidential. Consumer complaints will be heard promptly and resolved to the extent possible to the satisfaction of both the aggrieved individual and the service provider.

PROCEDURES:

1. Consumer or other individual making a complaint about the KVR Program services may communicate either verbally or in writing to the EET-Vice President, Luisa Machuca.
2. The EET Vice President will request from the consumer basic information concerning the complaint such as: Name, birth date, dates, location, employee(s) involved, nature of the complaint, and request for action.
3. The EET Vice President will advise the consumer of the intended follow-up plan for his/her complaint to include a plan and means of response.
4. The EET Vice President shall work through Kawerak Human Resources to investigate the complaint and prepare a summary of findings. Additional information may be requested of the consumer as necessary. An employee involved in an investigation of complaint is expected to respond within five working days.
5. The EET Vice President shall respond to the consumer concerning the investigation findings within 30 days, or as agreed to in the follow-up plan, either verbally or in writing.
6. The EET Vice President will review all written communication with the consumer before being mailed.
7. If a satisfactory resolution to the complaint is not reached through the preceding actions, the consumer may appeal in writing to the Kawerak Executive Vice President, Mary David, who will review the record and respond within 10 working days. If no agreement is reached the appeal then goes to the President of Kawerak Inc., Melanie Bahnke.

If the consumer chooses not to handle his or her problem internally, The Client Assistance Program is always available to help. Please see brochure in this packet or contact the EET Intake Coordinator at (907) 443-4358.

Applicant Copy – Keep this page for your records.

Kawerak, Inc.
Education, Employment and Training Services

Appeals Process

Purpose. The purpose of the appeals process is to provide for an orderly process whereby applicants may have their problems or concerns addressed as fairly and rapidly as possible.

Applicability. This process is available to all applicants seeking services from Kawerak's Education, Employment & Training Division.

Definition of the Appeal Process. The term "appeal process" means to apply for review of a case or decision to be reconsidered or addressed by the next a level of authority.

Procedure. The procedure for an applicant, who expresses dissatisfaction with the decision for denial of services, would be to first informally talk with the person making the decision who will review with him/her the basis for which the decision was made and confirm the facts and the related decision. If error was made or new additional evidence justifies modifying the decision, appropriate adjustments will be made.

(1) If the applicant continues to be dissatisfied after the above review, the applicant can appeal a decision individually or select a representative to assist them in resolving the appeal at their expense. The applicant may proceed with the appeal to the next supervisory level.

(2) The applicant must submit a written document stating the problem or concern and request a meeting to the Division Vice-President (VP) of Kawerak. Upon receipt of the written appeal the VP shall meet with the applicant and seek to resolve the issue(s). The VP will have ten (10) working days upon receiving the appeal to resolve the issue with the applicant.

(3) In the event that the VP is not able to resolve the appeal to the satisfaction of the applicant, the applicant may provide the appeal to the Executive Vice-President (EVP.) Upon receipt of the appeal, the EVP shall meet with the applicant and seek to resolve the situation. The EVP will have ten (10) working days upon receiving the appeal to resolve the issue(s) with the applicant. The Appeal Process will be followed at each level through the supervisory chain up through the President, if necessary, until the appeal is resolved.

(4) If the appeal must be submitted to the President, after reviewing the written documentation and conferring with the parties concerned, the President shall within ten (10) working days take appropriate action which must be in writing and may be in the form of a recommendation to the supervisory levels and the applicant, or an order requiring the compliance with applicable rules and regulations. The President may also determine that the appeal is without merit and dismiss it.

(5) In the event the President is not able to resolve the appeal to the satisfaction of the applicant, the applicant may provide the appeal to the Kawerak Board Executive Committee. After reviewing the written documentation and conferring with the parties concerned, the Executive Committee shall within thirty (30) working days take appropriate action to resolve the issue(s) which must be in writing and may be in the form a recommendation to the President and the applicant, or an order requiring the compliance with applicable rules and regulations. The decision of the Kawerak Board Executive Committee shall be final.

Applicant appeals shall take no longer and be resolved within sixty (60) working days.

If the applicant continues to be dissatisfied, the appellant may appeal at the Federal level. Questions about or complaints alleging a violation of the nondiscrimination provisions of WIA section 188 may be directed or mailed directly to: the Director, Civil Rights Center, U.S. Department of Labor, Room N-4123, 200 Constitution Avenue, NW, Washington, D.C. 20210