

DELAWARE NATION VOCATIONAL REHABILITATION DOCUMENT LIST

Applicant must provide at least one form of documentation for each of the following areas indicated. The lettered items are some examples.

DOCUMENTS REQUIRED:

1. _____ PROOF OF INCOME (include Tax Returns and all income for all household members.)

- A. Social Security Award Letter or VA Award Letter
- B. Copy of Benefits Check(s)
- C. Income Verification from the Department of Human Services (Welfare)
- D. Wages
 - 1. Letter for Employer
 - a. Must be on letterhead stationary or notarized
 - b. Must include dates of employment and gross wages for the month
 - 2. Copy of check stub

2. _____ PROOF OF INDIAN BLOOD/AGE

- A. CDIB Card or Tribal Membership Card
- B. Census Card or letter from Agency

3. _____ PROOF OF SOCIAL SECURITY NUMBER

- A. Social Security Card
- B. Driver's License

4. _____ PROOF OF MAILING ADDRESS/RESIDENTIAL VERIFICATION

- A. Utility Bill
- B. Driver's License
- C. Rent Receipt
- D. Voter's Registration Card

5. _____ PROOF OF DISABILITY

- A. Doctor's Statement (verifying disability)
- B. School Assessment Records
- C. Copy of SSDI Check, Aid to Disabled Check, VA Disability Check or SSI Check

DELAWARE NATION
VOCATIONAL REHABILITATION
GENERAL HEALTH CHECKLIST

NAME _____ SSN# _____ CSLR _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

Please answer "YES" or "NO" to all items.
Do you have.....

**If yes, has it Kept
you from working**

	YES	NO	YES	NO
1. A disorder of eyes, ears, nose or throat?.....	()	()	()	()
2. Frequent dizziness, fainting, or headaches; seizure, convulsions, paralysis, or stroke?.....	()	()	()	()
3. A mental or nervous disorder?.....	()	()	()	()
4. Persistent coughing, bronchitis, asthma, emphysema, Tuberculosis or other disorder of your lungs?.....	()	()	()	()
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels?.....	()	()	()	()
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of stomach, intestines, liver, or gallbladder?...	()	()	()	()
7. Disorder of kidney, bladder, prostate or reproductive system?.....	()	()	()	()
8. Diabetes, thyroid, or other endocrine disorders?.....	()	()	()	()
9. Arthritis or other disorder of the muscles or bones including the spine, back or joints?.....	()	()	()	()
10. Absence or amputation of any body part?.....	()	()	()	()
11. Loss of use of arms and legs or other body part?.....	()	()	()	()
12. A tumor, cancer, or disorder of skin or lymph.....	()	()	()	()
13. Allergies?.....	()	()	()	()
14. Anemia or other disorder of the blood?.....	()	()	()	()
15. Excessive use of alcohol or any habit-forming drugs?....	()	()	()	()
16. Any other physical or mental condition?.....	()	()	()	()

If yes, specify: _____

17. Name and address of your personal physician/clinic: (if none, so state)

PLEASE ANSWER THESE QUESTIONS FOR ANY CONDITION MARKED "YES" ON THE FIRST PAGE:

18. Have you been or are you being treated for any of these conditions? () YES () NO

If NO, why not? _____

If YES,

Condition	Who treated you	When
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Have you been hospitalized for any of these conditions? () YES () NO

If Yes,

Condition	Where	When
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. Are you taking any medicines? () YES () NO

If yes,

Condition	What medicines
_____	_____
_____	_____
_____	_____

21. Do you have any restrictions from these conditions? () YES () NO

If, yes,

Condition	What restrictions
_____	_____
_____	_____
_____	_____

To the best of my knowledge, what I have said is true and I have not withheld any information.

(date)

(Signature of applicant)

Person who provided information, if not applicant: _____

comments: