SUPPLEMENTAL APPLICATION FOR VOCATIONAL REHABILITATION SERVICES
THREEE AFFILIATED TRIBES VOCATIONAL REHABILITATION PROGRAM
SFN 263 (REV 01-2002)

NAME (LAST, FIRST, MIDDLE INITIAL	SOCIAL SECURITY NUMBER
MY DISABILITY IS	
I HEARD ABOUT VOCATIONAL REHABILITATION THROUGH	

I am requesting services through Vocational Rehabilitation (VR) because I intend to become employed or continue in employment. I will keep VR informed about changes of address, training plans, employment opportunities or changes in my relationship with VR.

I authorize VR to gather information about me in order to determine my eligibility for services, identify appropriate services, and provide services. I understand that information about me is provided voluntarily, and if it is not provided, it may affect decisions about my eligibility and services. I also understand the information can be released by VR upon my written request and as allowed by state and federal law.

I understand that I cannot on the grounds of race, color, religion national origin, sex, political beliefs, age or nature of disability, be discriminated against in any matter related to the receipt of any service, financial aid, or other benefit under the VR program.

The services of the Client Assistance Program (CAP) have been explained to me and I have also received written CAP information.

I understand that if I am not satisfied with a determination made by VR, I can request mediation services by contacting my VR counselor; I may contact the Client Assistance Program, or I may request a fair hearing. If I request a fair hearing, I will write to: Appeals Supervisor, Department of Human Services, State Capitol, 600 East Boulevard Avenue, Bismarck, ND 58505. A request for a hearing must be made within 30 days of the determination.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF PARENT OR GUARDIAN (IF APPLICANT UNDER AGE 18)	DATE

COPY TO APPLICANT