PERSONAL DATA FORM
THREEE AFFILIATED TRIBES
VOCATIONAL REHABILITATION PROGRAM
SFN 93 (Rev. 3-09)

Name:	**Maiden/Other Name:**
Address 1:	
Address 2:	
City, State, Zip Code:	**E-mail:**
County of Residence:	**Telephone Number:** ( )
Social Security Number:	**Cell Phone Number:** ( )
Date of Birth: (Month/Day/Year)	**Gender** ☐ **Male** ☐ **Female**

Race/Ethnicity (Select all that apply):

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

☐ Hispanic or Latino*

NOTE: If this is selected, at least one of the above must also be selected.

Work Status (Select only one):

- ☐ * Employed, making at least minimum wage **[1]**
- ☐ * Self Employed **[3]**
- ☐ * Randolph Sheppard Program **[4]**
- ☐ * Sheltered Workshop **[2]**
- ☐ Homemaker **[5]**
- ☐ Unpaid Family Worker **[6]**
- ☐ Not employed: Student in Secondary Education **[10]**
- ☐ Not employed: Trainee, Intern or Volunteer **[9]**
- ☐ Not employed: Other **[8]**

*If selected, Hours worked last week: _____

If Hours entered,
Earnings last week: $ _____

Highest Level of Education Attained (Select only one):

- ☐ No formal schooling **[0]**
- ☐ Elementary education (grades 1-8) **[1]**
- ☐ Secondary education, no high school diploma (grades 9-12) **[2]**
- ☐ Special Education Certificate of Completion or Attendance; received Special Education but no certificate; currently in Special Education **[3]**
- ☐ High school graduate or equivalence certificate (GED) (regular education students) **[4]**
- ☐ Post-secondary education, no degree **[5]**
- ☐ Associate degree or Vocational/Technical Certificate **[6]**
- ☐ Bachelor's Degree **[7]**
- ☐ Master's degree or higher **[8]**

Have you ever received services under an Individualized Education Program (IEP)?

☐ **Yes** ☐ **No**

Number of Dependents:
(Do not count yourself) _____

For Office Use Only:

Referral Date: _____

Counselor: _____

Disability at Referral: _____

Primary Source of Support (Select only one that represents your largest single source of economic support):

- ☐ Personal Income (earnings, interest, dividends, rent) **[99]**
- ☐ Family, Friends (includes earnings of spouse, or spouse's unemployment insurance checks) **[01]**
- ☐ Public Support (SSI, SSDI, TANF, etc.) **[03]**
- ☐ All Other Sources of Support (e.g., private disability insurance and private charities) **[10]**

Living Arrangement (Select only one):

- ☐ Private Residence **[99]**
- ☐ Mental Health Facility **[04]**
- ☐ Community Residential/Group Home **[05]**
- ☐ Substance Abuse Treatment Center **[07]**
- ☐ Deaf School or Other Inst. For the Deaf **[10]**
- ☐ Rehabilitation Facility **[11]**
- ☐ Nursing Home **[13]**
- ☐ Halfway House **[14]**
- ☐ Adult Correctional Facility **[15]**
- ☐ Homeless/Shelter **[18]**
- ☐ Other **[17]**

Please indicate if you are a:

- ☐ Veteran
- ☐ Migrant or Seasonal Farmworker

Source of Referral (Select only one):

- ☐ Educational Institution (elementary/secondary **[14]**
- ☐ Educational Institution (post-secondary) **[10]**
- ☐ Community Rehabilitation Program **[30]**
- ☐ Medical Personnel, Institution, or HSC **[32]**
- ☐ Public Welfare Agency (State or local govt) **[40]**
- ☐ Private Welfare Agency **[44]**
- ☐ SSA (DDS or district office) **[50]**
- ☐ Workforce Safety & Insurance Agency **[52]**
- ☐ One-Stop Employment/Training Center **[53]**
- ☐ Correctional Institution, Court, Officer **[56]**
- ☐ Employer **[62]**
- ☐ Self-referral **[70]**
- ☐ Other **[79]**

Do you have Medical Coverage? ☐ **Yes** ☐ **No** **If yes, select all that apply:**

- ☐ Medicaid
- ☐ Medicare
- ☐ Public Insurance Through Other Means (e.g. Workforce Safety or IHS)
- ☐ Private Insurance Through Employment
- ☐ Private Insurance Through other Means **(Name of Company)** _____

Type of Public Assistance I am Now Receiving (Select all that apply):

- ☐ None
- ☐ TANF - Amount $_____/Month
- ☐ General Assistance (GA) - Amount $_____/Month
- ☐ Veterans Disability (VA) - Amount $_____/Month
- ☐ Workforce Safety & Insurance - Amount $_____/Month
- ☐ Other Public Support **(Includes Social Security Survivor/Retirement Benefits)** - Amount $_____/Month
- ☐ SSI - Amount $_____/Month SSI Start Date: _____
- ☐ SSDI - Amount $_____/Month SSDI Start Date: _____

List of Family Members in Your Home Now

Name	Age	Relationship	Employment

Name of individual (other than spouse) who will always know your address and/or telephone number:

Name:	Please initial & date here to indicate your permission to contact this person, if necessary:

Address:

City, State, ZIP

Telephone Number: ( )	Cell Phone Number: ( )

Education

Last School Attended: (high school, college)

Other Training:

Aptitude or Interest Tests You Have Taken:

Where:	When:

Employment History

Employer	Nature of Work	Dates	Weekly Earnings

Are you registered with any Employment (Job Service) Office? ☐ Yes ☐ No Where:

I would be interested in this type of work:

Agency Contacts

I have contacted the following agencies within the past year:

Agency	Location
☐ Job Service Office	
☐ Human Service Center	
☐ Social Security Services	
☐ County Social Services	
☐ Private Welfare Agency	
☐ Veterans Administration	
☐ Workers Compensation	
☐ **Other:**	

Medical Services

I have received medical services at the following: (Names/dates of visit to hospital, clinic or doctor):

	Date:
	Date:
	Date:
	Date:

Describe how your disability affects your activity: