

Blind/Visually Impaired Deaf/Hard of Hearing Summer Youth Program Referral

Please complete the form and send to rsadhhreferrals@azdes.gov. By submitting this form I understand that my information will be entered into the RSA client system and I will be contacted by a representative of RSA.

INDIVIDUAL BEING REFERRED

Title: _____ Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (No., Street) _____

City _____ State _____ ZIP Code _____

Residential Address (No., Street) _____

City _____ State _____ ZIP Code _____

Home Phone Number _____ Cell Phone Number _____

Alternate Contact Number _____ Email _____

Video Phone Number _____ VRS IP: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

PARENT/LEGAL GUARDIAN (IF APPLICABLE)

Title _____

First Name _____ Last Name _____

Mailing Address (if different from above) _____

City _____ State _____ ZIP Code _____

Phone Number (if different from above) _____

Race / Ethnicity	Travel Information	What accommodations do you need for your first appointment?
White	Alone	Interpreter Services
Black or African American	With a Sighted Guide	ASL
Asian	With a Cane	Transliteration
Hispanic or Latino	With a Dog Guide	CART
Native Hawaiian or Pacific Islander	At Night	Large Print documents
American Indian or Alaska Native If checked: Tribal Affiliation:	During the Day	Braille documents
	On Public Transportation	Transportation assistance
	With a Wheelchair	Other- please list:
	With Assistive Devices	
	Other:	

PRIMARY LANGUAGE

Primary Language: _____

Other Languages or Modes of Communication: _____

NAME OF REFERRAL SOURCE

How did you hear about us? _____

Self-Referred

Do you have a DDD case worker? Yes No

If yes, what is the name of your case worker? _____

Do you receive services from a Behavioral Health Clinic? Yes No

If yes, what is the name of your case manager? _____

If yes, what is the name of your clinic? _____

Are you interested in attending the Blind and Visual Impairment Summer Youth Program? Yes No

WHAT IS YOUR DISABILITY(IES) PLEASE CHECK ALL THAT APPLY

- | | | | |
|-------------------|--------------------------------|-------------------------|---------------------|
| Behavioral Health | Blind or Visually Impaired | Deaf or Hard of Hearing | Developmental Delay |
| Cognitive Delay | Other: (please describe) _____ | | |

Do you want to work? Yes No

If yes, please describe your job goal below.

Are you a family member or close associate of an RSA program employee? Yes No

Optional: Please disclose the name of the family member or close associate. _____

Date Submitted: _____