ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

REFERRAL TO VOCATIONAL REHABILITATION

Member's Name *(Last, First, M.I.)*: _____ Date: _____

DOCUMENTS INCLUDED IN THE VOCATIONAL REHABILITATION PACKET:	CHECK ALL THAT APPLY:
☐ Current Planning Document *(required)*	☐ ALTCS
Documented Disability Documentation *(required – one or more documents)* ☐ Medical Evaluation(s) *(including diagnostic information)(required)* ☐ Psychological Evaluation(s) *(including diagnostic information) (required for Members with Intellectual Disabilities)* ☐ Vocational Evaluation(s) ☐ School Records *(MET Reports and Individualized Employment Program)*	☐ DDD Only ☐ Targeted ☐ RBHA-General Mental Health *(GMH)* ☐ RBHA-Serious Mental Illness *(SMI)*
☐ Behavioral Health Records	☐ Current/Former Child in Foster Care
☐ Most Current Guardianship Documents *(required – if member has a guardian)*	☐ Visual Impairment
☐ Authorization/Consent For Disclosure and Use of Confidential Information Between DDD and RSA RSA-1365A *(required)*	☐ Hearing Impairment

Member's Home Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Member's Mailing Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Member's Phone Number: _____ Member's Primary Language: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Primary Diagnosis (DDD): _____

Behavioral Health Diagnosis: _____

Guardianship: ☐ Yes ☐ No Expiration Date: _____ Guardian's Primary Language: _____

Guardian Name: _____ ☐ Department of Child Safety (DCS) Specialist

Guardian's Mailing Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____ Guardian's Phone Number: _____

Contact Person: _____ Relationship: _____

Contact Person's Primary Language: _____ Contact Person's Phone Number: _____

LIVING ARRANGEMENT:

☐ Lives Independently ☐ Family Home ☐ Child Developmental Home *(CDH)* ☐ Adult Developmental Home *(ADH)*

☐ Group Home ☐ Intermediate Care Facility *(ICF)* ☐ Other *(specify):* _____

Highest Level of Education or Current School Placement: _____

Other Education/Training: _____

INCOME SOURCE(S) *(List monthly amount)*:

SSI: _____ SSDI: _____ Earnings: _____ Other: _____

Current Day/Vocational Program and Provider's Name: _____

See page 2 for EOE/ADA disclosures

Current Means of Transportation/Specialized Transportation Needs *(example: wheelchair lift)*:

Reason for Referral to Vocational Rehabilitation: ☐ Competitive Employment ☐ WIOA/511 Subminimum Wage

Vocational Outcome/Objective:

Vocational History *(Current and past vocational training, work experiences, accomplishments and skills)*:

I have reviewed the referral to Vocational Rehabilitation. All required information is included, and referral packet is complete.

Support Coordinator's Name *(Print or Type)*: _____

Support Coordinator's Signature: _____ Date: _____

Support Coordinator Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Support Coordinator Phone Number: _____ Email: _____

As the supervisor I have reviewed all required information and referral packet is complete.

Support Coordinator Supervisor's Name: _____

Support Coordinator Supervisor's Signature: _____ Date: _____

Support Coordinator Supervisor's Phone Number: _____ Email: _____

TO BE COMPLETED BY THE DISTRICT EMPLOYMENT SERVICE SPECIALIST

Date referral packet submitted to Vocational Rehabilitation: _____

Vocational Rehabilitation Office and Contact: _____

Vocational Rehabilitation Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Vocational Rehabilitation Phone Number: _____

If the member is referred to Vocational Rehabilitation, is funding available for extended supported employment services if needed to maintain successful employment? ☐ Yes ☐ No ☐ N/A

District Program Manager/Designee's Name: _____

District Program Manager/Designee's Signature: _____ Date: _____

If the member will not be referred to Vocational Rehabilitation, will Employment Supports and Services be requested from the Division? ☐ Yes ☐ No ☐ N/A

If Yes, complete the question below and attach documentation explaining why a referral to Vocational Rehabilitation is not necessary.

Employment Specialist Name *(Print or Type)*: _____

Employment Specialist Signature: _____ Date: _____

Employment Specialist Phone Number: _____ Email: _____