ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Rehabilitation Services Administration

REFERRAL FORM

You may fill out this form electronically and email it to azrsa@azdes.gov or you may print this form and take it to the RSA office closest to you. To locate the office closest to you, call 1-800-563-1221 or visit the web at www.azdes.gov/rsa and click on Contact Information.

To speak with someone regarding general information about RSA programs or to receive assistance completing a referral for services, please call Toll-Free 1-800-563-1221. 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.

See page 7 for EOE/ADA disclosures

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?

_____

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: _____

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact your local RSA office; TTY/ TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local.