ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

REFERRAL TO VOCATIONAL REHABILITATION PACKET

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: _____

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: _____

AUTHORIZATION/CONSENT FOR DISCLOSURE AND USE OF CONFIDENTIAL INFORMATION BETWEEN DDD AND RSA

(Including Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Covered Records)

I, the undersigned individual or legal representative, hereby authorize the disclosure and use of confidential client information between the Division of Developmental Disabilities (DDD) and the Rehabilitation Services Administration (RSA) regarding:

Name: _____ Also Known As (AKA) / Maiden Name: _____

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Date of Birth: _____ Authorization Expiration Date: _____ Phone Number: _____

The information may be disclosed to and used by:

☐ **DDD**

Attention: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

☐ **RSA**

Attention: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The purpose of the disclosure and use is:

☐ Medical
☐ DDD eligibility and service provision
☐ RSA eligibility and service provision
☐ Other *(Specify purpose)*: _____

Vocational Rehabilitation will not be able to rerelease any secondary source information.
The Type of information to be used or disclosed are as follows:

☐ Case Notes/Status Update
☐ Medical/Psychological Records (may contain secondary information)
☐ Individualized Plan for Employment (IPE)
☐ Individualized Service Plan (ISP)
☐ Program Eligibility
☐ Vendor Progress Notes
☐ Psychological Evaluations (may contain secondary information)
☐ Vocational Evaluations
☐ School Records (may contain secondary information)
☐ Behavioral Health Records (may contain secondary information)
☐ Guardianship Documents (may contain secondary information)
☐ Other *(Specify type and date)*: _____

- Controlling federal and state laws (45 CFR 160, 162 and 164 et seq,) 45 CFR 164.500 et seq, 34 CFR 361.38, A.R.S. § 41-1959, A.R.S. § 36-568.01, AAC R6-4-405) limit RSA and DDD release of confidential information. I understand that by signing this release I authorize the use and disclosure of my confidential information between the RSA and DDD.
- Reports and evaluations generated by RSA are intended for the sole purpose of planning and administering an individualize rehabilitation program and the provision of supported employment services.
- RSA may be in possession of secondary source information that is prohibited from re-release. This information may be requested from the original source through the client.
- RSA and DDD will not accept liability for the use of this information in any other manner than intended and authorized by the client.
- Confidential client information may not be used by the recipient for purposes not stated in this authorization.
- The recipient may not release confidential client information to others.
- I understand that once any HIPAA covered records and information authorized here are disclosed, they could be re-disclosed by the recipient and may no longer be protected by HIPAA. However, contracted health care and service providers generally are bound by contract and law to maintain the confidentiality of the health information received, especially relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.
- I understand that I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization excelp as provided under state or federal law.
- I understand that except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation, I may revoke this authorization/consent at any time by written notice to RSA and DDD.
- If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.
- I understand that I may have a copy of this signed authorization/consent if I request it.
- The parent or legal guardian must sign this authorization if the RSA applicant/client/DDD member is a minor (under the age of 18) or has a legal guardian.

Applicant/Client Signature: _____ Date: _____

Parent or Legal Representative's Signature: _____ Date: _____

If signed by the Legal Representative, indicate your relationship to the individual and provide appropriate documentation to verify your authority.

☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Other:** _____

A facsimile or photocopy of this authorization is considered to be as authentic as the original