ARIZONA DEPARTMENT OF ECONOMIC SECURITY Rehabilitation Services Administration

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				
Home Phone Number				
Cell Phone Number				
Alternate Contact Numb	er			
Email				
Video Phone Number				
VRS IP				
Date of Birth				
Social Security Number:				

PARENT/LEGAL GUARDIAN (IF APPLICABLE)

Title: First Name:					
Last Name:					
Mailing Address <i>(if diff</i>	ferent from above)				
	State	7TD Codo			

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
or Alaska Native If checked: With With	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: (<i>please describe)</i>					
Do you want to work?	Yes	No			
If yes, please describe your job goal below.					
Are you a family member or clo	se associate	of an RSA program			
employee?	Yes	No			
Optional: Please disclose the na	me of the fai	mily 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.