

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 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?

**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.