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.

	INDIVID	UAL BEING RE	FERRED		
Title:	Last Name:	F	irst Name:	Middle Initial	:
Mailing Address (No., Street)					
City			State	ZIP Code	
Residential Address (No., Stre	eet)				
City			State	ZIP Code	
Home Phone Number		Ce	ell Phone Numb	per	
Alternate Contact Number		Email _			
Video Phone Number		VRS IP:			
Date of Birth:	Gender:	;	Social Security	Number:	
	PARENT/LEGA	L GUARDIAN (I	F APPLICAB	LE)	
Title					
First Name			_ Last Name	·	
Mailing Address (if different from	om above)				
City			State	ZIP Code	
Phone Number (if different fro	m 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	During the Day	Braille documents		
If checked: Tribal Affiliation:	On Public Transportation	Transportation assistance		
	With a Wheelchair	Other- please list:		
	With Assistive Devices			
	Other:			

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	PRIMARY I	LANGUAGE			
Primary Language:					
Other Languages or Mode	es of Communication:				
	NAME OF REFE				
How did you hear about u	us?				
Self-Referred					
Do you have a DDD case worker?			Yes	No	
If yes, what is the name o	of your case worker?				
Do you receive services from a Behavioral Health Clinic?			Yes	No	
If yes, what is the name o	of your case manager?				
If yes, what is the name o	f your clinic?				
WH	IAT IS YOUR DISABILITY(IES) I	PLEASE CHECK A	ALL THA	T APP	LY.
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 yo	ur job goal below.				
Are you a family member	or close associate of an RSA progra	am employee?	Yes	No	
Optional: Please disclose	the name of the family member or o	close associate			
Date Submitted:					