

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.

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.

GENERAL CONTACT INFORMATION

Title: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

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: _____

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 • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. 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. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.