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 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:	

See page 2 for EOE/ADA disclosures

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.