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| **VR Referral Form**  for Employment & Community First (ECF) CHOICES Member to Vocational Rehabilitation (VR) |

*THIS FORM MUST BE TYPED*

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| --- | --- | --- | --- | --- |
| **ECF CHOICES Member Information:** | | | | |
| First Name: | | Middle Name: | | Last Name: |
|  | |  | |  |
| Date of Birth: | --Click here to enter a date-- | | Age: |  |
| Gender: | --Male/Female-- | | SSN: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Street Address: | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | Suite/Apt #: |  |
| City: | | | | State: | | | Zip Code: | | | | | County: | |
|  | | | |  | | |  | | | | |  | |
| Main Residence? | | | --Yes/No-- | | | | Mailing Address? | | | --Yes/No-- | | | |
| Home Phone: | | | | | | Cell: | | | | | Alt Phone: | | |
|  | | | | | |  | | | | |  | | |
| TTY: |  | | | | | | | Email: |  | | | | |
| Preferred Method  of Contact: | | | | | --Choose One-- | | | | | | | | |

|  |  |
| --- | --- |
| Primary Language: | Other Language: |
|  |  |
| Manual Communication Mode: | Preferred Written Communication Medium: |
|  |  |

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| Transportation & Mobility (choose all that apply): |
| w/Cane  w/White Cane  w/Assistive Devices  w/Wheelchair  on Public Transportation  Other |

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| **Representative’s Information:** | | | | | | | | | | | | |
| First Name: | | | | | | | Last Name: | | | | | |
| Lives with Applicant? | | | --Yes/No-- | | | | | | | | | |
| Street Address: | |  | | | | | | | | | | |
|  | | | | | | | | | | Suite/Apt #: | |  |
| City: | | | | State: | | | Zip Code: | | | | County: | |
|  | | | |  | | |  | | | |  | |
| Home Phone: | | | | | Cell: | | | | Alt Phone: | | | |
| TTY: |  | | | | Email: |  | | | | | | |
| Relationship: | | | | | Legal Guardian? | | | --Yes/No-- | | | | |
|  | | | | | Receive Mail? | | | --Yes/No-- | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Support Coordinator Information:** | | | | | | | | | | | |
| First Name: | |  | | | Last Name: | | |  | | | |
| MCO: |  | | | | | | | | | | |
| Phone: |  | | | | Email: | |  | | | | |
| Street Address: | | |  | | | | | | | | |
|  | | | | | | | | | Suite #: | |  |
| City: | | | | State: | | Zip Code: | | | |  | |

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| **Documentation that *must* be submitted with this referral form:** | | | |
|  | Release of Confidential Information | | |
|  | Comprehensive Needs Assessment, or equivalent | | |
|  | Person-Centered Support Plan | | |
|  | Disability documentation, including Social Security benefits approval letter, if available – *strongly encouraged to expedite VR eligibility* | | |
| **If available, documentation to be submitted with this referral form:** | | | |
|  | Guardianship documents, if applicable | | |
|  | ECF CHOICES employment service report(s), if applicable | | |
|  | | | |
| **IMPORTANT ADDITIONAL INFORMATION** | | | |
| Individual is currently receiving ECF CHOICES Pre-Employment Service(s) that are expected to finish on **Date:** | | | |
| Individual has job offer and needs coaching to stabilization. **Date Job Starts:** | | | |
| Individual has a job and wants career advancement (second job or promotion). | | | |
| **Name of ECF CHOICES Employment Service Provider, if involved:** | | | |
|  | | | |
| **ECF CHOICES Support Coordinator**  **(Print Name):** | | | **Signature:** |
|  | | |  |
| Date: | | --Click here to enter a date-- | |