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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: |  |

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| --- | --- |
| 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-- |

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| 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-- |

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| **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 |
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| **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--  |