DIVISION of DISABILITY and REHABILITATIVE SERVICES
VOCATIONAL REHABILITATION SERVICES

VOCATIONAL REHABILITATION REFERRAL

VR Case Coordinator Name:	Date of Referral (mo, day, yr):	
LAST Name of Customer:	FIRST Name:	Middle Initial:
Nickname if any:	Date of Birth:	Sex: ☐ M ☐ F
Social Security Number:	Phone #: (check if preferred ☐)	Cell #: (check if preferred ☐)
E-mail:	Preferred Mode of Communication? ☐ US Mail ☐ E-Mail ☐ Phone ☐ Cell/Text	
Residence Address:	City:	State: / Zip Code:
Mailing Address if different:	City:	State: / Zip Code:

Who referred you to our program? (Self, School, Therapist, Doctor, Agency, SSA, etc.) Angela Resendez Tran. Coor | Source's Phone Number:

Stated Disability (What is the disability(ies) in the customer's words?):

What do you hope VR can do for you? (expectations):

If non-English or deaf/hard of hearing, is an interpreter or translator needed? ☐ YES ☐ NO | If YES, what language?

Are you currently a Student? ☐ NO - Not a student with a disability in secondary education
☐ YES - A student: ☐ with 504 accommodation plan ☐ in IEP ☐ not in any program or receiving services
Expected Date of Graduation: School Code:

APPOINTMENT WITH VR

VR COUNSELOR ASSIGNED:	APPOINTMENT DATE AND TIME:

Comment/Notes: