

Date: _____



Referral to

Customer Name: _____ Date of Birth: _____
 Phone Number: _____ Msg. Phone: _____
 Home Address: _____ Email: _____
 City _____ State _____ Zip Code _____

Referred by: _____ Office: _____ Phone #: _____

Guardianship: yes no

If yes, guardian name and phone number: _____

Emergency Name and Contact Info: _____

Contact, if not customer, to schedule appointments: _____

Contact phone number: _____

- Customer has Targeted Service Coordinator
- Customer has Residential Habilitation Services
- Other Contacts: _____

*Contact Information for additional contacts is available in attached contact pages

- VRC/S has verified the customer has documents needed for completion of I-9
 Documents viewed: _____

Services to be Performed

Employment Services

- Job Readiness Training
- Job Search Assistance
- Job Supports – Short Term
- Supported Employment: Job Coaching

Assessment

- Assessment: Staffing
- Assessment: CBWE
- Assessment: CBWE – Site Development

Pre-ETS Services

- Pre-ETS WRT
- Pre-ETS WBLE

Disabilities (Primary list first):

Barriers (Functional limitations):

Known/Anticipated Accommodations:

Valid Driver's License? Yes No Personal Vehicle? Yes No

Alternate transportation available? Bus Pass Family/Friend

Bike Other: _____