Arizona Department of Economic Security
Rehabilitation Services Administration

Vocational Rehabilitation (VR) Referral Form

You may fill out this form electronically and email it to azrsa@azdes.gov or print it and take it to the Vocational Rehabilitation office closest to you. To locate the office closest to you, call 1-800-563-1221 or visit the web at des.az.gov/rsa and click on Contact Information.

For general information about the Vocational Rehabilitation program or to get help completing this referral form, 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 a representative of Vocational Rehabilitation will contact me.

Public Benefit Requirements

Vocational Rehabilitation (VR) is a state and federally funded program that provides public benefits. To qualify for any public benefit, you must be a U.S. citizen, a legal resident of the United States, or legally present in the United States. Please check the statement that applies to you:

- ☐ U.S. citizen
- ☐ Legal resident of the United States or lawfully present in the United States

All individuals interested in the VR program must provide their Social Security card and documentation to verify their identity and employment authorization to apply for the VR program.

Individuals who are not U.S. citizens are required to provide immigration documentation to confirm they meet the requirements for public benefits.

Individual Being Referred

Title: _____ Last Name: _____ First Name: _____ Middle Initial: ____

Mailing Address *(Number, Street)*: _____

City: _____ State: _____ ZIP Code: _____

Residential Address *(Number, 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 of a Minor/Court-Appointed Legal Guardian Information *(if applicable)*

If the individual being referred to Vocational Rehabilitation is a minor or has a court-appointed legal guardian, include the parent or guardian's information.

Title: _____ First Name: _____ Last Name: _____

Mailing Address *(if different from above)*: _____

City: _____ State: _____ ZIP Code: _____

Phone Number *(if different from above):* _____

See page 2 for EOE/ADA disclosures

Race / Ethnicity *(select all that apply)*	**Travel Information**	**What accommodation(s) 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	
☐ Decline to self-identify	☐ Other:	

Primary Language

Primary Language or Dialect: _____

Other Languages or Modes of Communication: _____

Name of Referral Source

How did you hear about us? ☐ Self-Referred ☐ Other _____

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

Have you been determined eligible to receive Serious Mental Illness (SMI) services in the State of Arizona? ☐ Yes ☐ No

If yes, what is the name of your case manager? _____

If yes, what is the name and address of your clinic? _____

_____

What is Your Disability(ies) *(please check all that apply)*

☐ Mental 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: _____

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: _____