CHOICE, unlimited

Creating & Enhancing Opportunities Within Local Communities

REFERRAL FORM

Name: *(First Middle Last)*	Referral Date: Proposed Start Date:
Social Security Number:	Date of Birth:
Address:	
Phone:	County:
Legal Status: ☐ Responsible for Self ☐ Under Guardianship ☐ Under Commitment	

Please check all that apply.

Funding source:

☐ DD Waiver ☐ CADI Waiver ☐ BI Waiver ☐ VRS (MN) ☐ DVR (WI) ☐ IRIS (WI)
☐ Consumer Directed Community Services (CDCS) ☐ Private Pay ☐ Grant ☐ Other: _____

Selected services:

☐ Day Support Services
☐ Prevocational Services
☐ Individualized Home Supports with Training
☐ Individualized Home Supports without Training
☐ Employment Services: *(choose from the following)*
☐ Other: _____
☐ Employment Development ☐ Employment Support ☐ Employment Exploration
☐ VRS/DVR: *(choose from the following)*
☐ On the Job Evaluation ☐ Job Shadowing ☐ Internship ☐ Customized Employment
☐ Pre-ETS ☐ PBA ☐ Other: _____

Referring agency:

☐ County Social Services (specify county): _____
☐ Rehabilitation Services (VRS/DVR/SSB)
☐ School Transition Services (specify school): _____
☐ Self
☐ Other (specify): _____

Phone: _____ **Email: _____**

Referral Contact Person: _____

Reason for referral and anticipated outcomes:

Primary Diagnosis:
Secondary Diagnosis:
Other significant medical considerations (allergies, etc.):

Legal Representative: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____

Address: _____

Relationship: _____

_____

Signature & Title of Person Completing and Approving this Referral* Date

*If county funded, I hereby verify that these services will not replace services which are the responsibility of local educational/vocational rehabilitation agency.