

**PART I Referral Information (to be completed by referring agency at time of referral)**

1. CLIENT NAME \_\_\_\_\_ 2. SSN \_\_\_\_\_  
3. ADDRESS \_\_\_\_\_ 4. PHONE \_\_\_\_\_  
5. AMT OF INCOME: SSI \$ \_\_\_\_\_ OTHER \$ \_\_\_\_\_ EXPLAIN \_\_\_\_\_  
MEDICAID YES ( ) NO ( ) 6. BIRTHDATE \_\_\_\_\_  
7. \*REPORTED DISABILITY \_\_\_\_\_  
8. SERVICES REQUESTED \_\_\_\_\_

\*PLEASE ATTACH AVAILABLE MEDICAL & PSYCHOLOGICAL INFORMATION & LIST KNOWN SOURCES OF ADDITIONAL INFORMATION

**PART II Results of Referral to DRS: (to be completed by DRS and returned to referring agency at closure)**

9. ( ) CLIENT FOUND ELIGIBLE FOR SERVICES, DATE: \_\_\_\_\_  
DATE OF IPE \_\_\_\_\_  
VOCATIONAL GOAL \_\_\_\_\_  
CLIENT CLOSED SUCCESSFULLY, EMPLOYED DATE: \_\_\_\_\_  
(Please notify referring agency of intent to close 2 weeks prior to closure)  
10. ( ) CLIENT INELIGIBLE FOR SERVICES, DATE: \_\_\_\_\_  
( ) DISABILITY TOO SEVERE/UNFAVORABLE MEDICAL PROGNOSIS  
( ) NO DISABLING CONDITION  
( ) NO IMPEDIMENT TO EMPLOYMENT  
( ) OTHER \_\_\_\_\_

**PART III Results of Referral to Other Agency: (to be completed and sent to DRS at time of determination)**

11. ( ) CLIENT IS ELIGIBLE FOR ONGOING FUNDING/SUPPORT FOR SUPPORTED EMPLOYMENT.  
12. ELIGIBLE FOR OTHER SERVICES  
( ) DAY TRAINING/TREATMENT  
( ) RESIDENTIAL SERVICES  
( ) FAMILY SUPPORT/RESPITE CARE  
( ) TRANSPORTATION  
( ) COUNSELING  
( ) MEDICATION MANAGEMENT  
( ) OTHER (Specify): \_\_\_\_\_  
13. CLIENT INELIGIBLE FOR SERVICES (Reason): \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
DRS COUNSELOR SIGNATURE DATE

\_\_\_\_\_  
OTHER AGENCY REPRESENTATIVE SIGNATURE DATE

\_\_\_\_\_  
DRS OFFICE ADDRESS

\_\_\_\_\_  
AGENCY ADDRESS

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
PHONE