



Referral to Vocational Rehabilitation

Vocational Rehabilitation (VR) is here to help individuals with disabilities prepare for, advance in, or retain employment.

Date of Referral _____

Name of Individual (Please print)		Date of Birth	Social Security Number (SSN)*	
Address (Home)		City	State	Zip
Address (Mailing)		City	State	Zip
Telephone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell		Additional Contact Name		
What is the best method of contact? (Select one) <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Other (specify) _____		Additional Contact Phone Number		
		Additional Contact E-mail		
Can VR leave a message at the number listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Does not wish to disclose or self-identify		
E-mail Address		Have you ever received services from VR? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Education Level		
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Does not wish to disclose or self-identify		Race (Check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Does not wish to disclose or self-identify		
Accommodations Do you require an Interpreter? <input type="checkbox"/> Yes, ASL <input type="checkbox"/> Yes other, specify language: Do you require an assistive listening device? <input type="checkbox"/> Yes Do you require translated documents? <input type="checkbox"/> Yes Do you require any other accommodations for your impairment? <input type="checkbox"/> Yes If so, please explain:				
What impairment prevents you from working?				
How can VR help you become employed?				
Current school attending:				
How did you hear about us?				
Agency/Vendor/School:		Contact Person:	Phone #:	

Please complete this page then mail or turn in the referral to the nearest VR office. For a list of offices, go to www.rehabworks.org and then click on "Contact Us" and then select "Directory of Local VR Offices and Vendors"; or you may call our toll free number 1-(800)-451-4327 for more information.

*The Division is collecting your SSN for mandatory federal reporting as required by 34 C.F.R. §361.12 and RSA PD-16-04.

For Office Use	Received Date : _____	Outcome of Referral <input type="checkbox"/> Completed Application <input type="checkbox"/> Decided not to apply <input type="checkbox"/> Missed Orientation <input type="checkbox"/> Other _____
	<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> In Person <input type="checkbox"/> Fax	
	Contact Date: _____ Contacted by: _____	
	<input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> In Person	
	Orientation Scheduled: <input type="checkbox"/> Group <input type="checkbox"/> Individual Date: _____	
Additional Notes: _____		