Indiana VOCATIONAL REHABILITATION
Empowering People. Changing Lives.

REFERRAL FORM

*Items with asterisk are REQUIRED

Referral Date	Preferred Method of Communication ☐US Mail ☐ E-Mail ☐ Phone Call ☐ Text			*Veteran? ☐ Yes ☐ No
*LAST Name		*FIRST Name		MI
Nickname	*Date of Birth	*Sex ☐M ☐F	*Who Referred You?	
*Social Security Number	Phone (☐cell ☐home ☐other)	E-Mail		
*Residential Address		*City	*State	*Zip Code	*County
Mailing Address (if different)		City	State	Zip Code	County

*Living Arrangement?

☐Private Residence ☐Homeless/Shelter ☐Community Residential/Group Home
☐Correctional Facility ☐Mental Health Facility ☐Substance Abuse Treatment Center
☐Halfway House ☐Nursing Home ☐Rehabilitation Facility ☐Other

What is a brief description of your disability and how it effects your ability to work?

What are your expectations of Vocational Rehabilitation?

*Are You a Student? ☐ No – Not a student ☐ Yes – A student with 504 plan ☐ Yes – A student with an IEP ☐ Yes – Not receiving any services or in a plan	Race (check all that apply) ☐ White ☐ African American ☐ Am Indian & Alaska Native ☐ Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ Asian	
*School Name (Students Only)	*Graduation Year (Students Only)	Hispanic/Latino? ☐ Yes ☐ No

Vision Problems not corrected by glasses or contacts? ☐ Yes ☐ No

Do you speak English? ☐ Yes ☐ No	If Not, What Language?	Do you need an interpreter? ☐ Yes ☐ No
Are you Deaf/hard of hearing? ☐ Yes ☐ No	Do you use sign language? ☐ Yes ☐ No	Do you need an interpreter? ☐ Yes ☐ No

OFFICE USE ONLY

VR Counselor	Appointment Date and Time

Revised 5/24/2019