ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Rehabilitation Services Administration



# REFERRAL FORM

Please complete the form and send to rsadhhreferrals@azdes.gov. If you have any questions, you may contact Sue Kay Kneifel at skneifel@azdes.gov . By submitting this form I understand that my information will be entered into the RSA client system and I will be contacted by a representative of RSA.

## INDIVIDUAL BEING REFERRED

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

Mailing Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Residential Address *(No., 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/LEGAL GUARDIAN *(IF APPLICABLE)*

Title _____

First Name _____ Last Name _____

Mailing Address *(if different from above)* _____

City _____ State _____ ZIP Code _____

Phone Number *(if different from above)* _____

| Race / Ethnicity | Travel Information | What accommodations 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<br>If checked: Tribal Affiliation: | ☐ During the Day | ☐ Braille documents |
| | ☐ On Public Transportation | ☐ Transportation assistance |
| | ☐ With a Wheelchair | ☐ Other- please list: |
| | ☐ With Assistive Devices | |
| | ☐ Other: | |

See page 2 for EOE/ADA/LEP/GINA disclosures

## PRIMARY LANGUAGE

Primary Language: _____

Other Languages or Modes of Communication: _____

## NAME OF REFERRAL SOURCE

How did you hear about us? _____

☐ Self-Referred

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

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

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

## WHAT IS YOUR DISABILITY(IES) PLEASE CHECK ALL THAT APPLY

☐ Behavioral 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 below.

_____

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: _____

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact your local RSA office; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local.