For internal use only: Employee #____________

SIBLEY COUNTY DAC

REFERRAL FORM

Date:______________

Applicant's Name: ________________________________ DOB ________________________________

Current Address: ______________________ City ______________________ State: ______ Zip Code: ______

County:____ Social Security #:_________________________

Current Phone #: ____

Education (last grade/year completed):_____________ How many years of Special Education:_________

Degree/Certificate - Year:____

Primary Disability:____

Documentation Date of Disability:____

Secondary Disability:____

Documentation Date of disability: ____

Circumstances surrounding onset of disability/injury: ______________________________________

Referring Agency:____

Agency Address: ____

Billing Name and address (if different from above):____

Referring Counselor/Case Manager:_________________________Phone #: _________________________

Funding Source:

_____VRS ______DD Waiver ______ CADI Waiver ______ BI Waiver ______County Funding ______ICF ______School

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County-of-financial-responsibility:____

Name-of-case-manager: ____

Address:____

Phone: ______________________________ Email:____

Servicing County: (if applicable)

Is there a rep payee? ☐ no ☐ yes; please name ____

Is applicant eligible to work in the United States ☐ Yes ☐ No

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Reason for Referral: ____

Vendor Services Desired:

☐ Individual Employment Planning (Evaluation)
_____Number of weeks

☐ Placement Services

☐ Employee Development Services (Work Adjustment Training)

☐ Individual Placement Services Grant (Mental Health)

☐ Licensed Services(DT&H)

☐ Other ____

Expected Outcome:

☐ Evaluation Only

☐ Full-time Employment

☐ Part-time Employment

☐ Retraining delete

☐ Other: ________________

Significant Vocational Problems - i.e. motivation to work, geographic location, length of unemployment, lack of skills, history of employment difficulty: ____________________

Past Work Experience: ____________________

Applicant's stated vocational goal: ____________________

Rehabilitation Problem (vocational/social/Legal) that may affect employability, i.e. family or financial concerns:

____

____

Does Applicant have either: ______ Guardian
______ Conservator of ☐ Person and/or ☐ Finances

Name:____________________
Address:____________________
Phone number:____________________

Medical assistance #:
Other health coverage:
Restrictions: Specify physical, mental, emotional, social, educational, etc.
Medications (please list):
Hospital of preference: ____________________
Physician(s):____________________
Address:____________________
Date of last physical:____________________ Attached: Yes ☐ No ☐
Date of last psychological:____________________ Attached: Yes ☐ No ☐
Other:____________________ Attached: Yes ☐ No ☐
Special Medical Conditions (special diet, communications system, etc.):

____

____

Persons to be involved in planning (VRS or SSB, Counselor, Social Worker, Attorney, Claims Representative, etc.)
Name/Address/Title:____________________

Additional Comments: ____________________

____
Person completing this form

____
Legal Representative