Referral for DVR Services

This information is collected under the authority granted by 34 CFR § 361.38 for the purpose of facilitating vocational rehabilitation (VR) services. As mandated by this regulation and Wis. Stat. § 47.02(7), all personal information is kept confidential and released only with the informed consent of the consumer or their representative, or as required by law. Completing this form is voluntary, but not providing this information may result in service delays. Information collected may be used for administration of the VR program, coordination of services, and other purposes. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay.

Legal First Name	Preferred First Name	Middle Initial

Legal Last Name	Social Security Number - -	Date of Birth

Address or PO Box

City	State	Zip Code	County of Residence

In which Wisconsin county would you like to receive services?

E-mail Address

Telephone Number	Cell Phone Number

Do you give DVR permission to leave a message at the telephone numbers listed above?

☐ Yes ☐ No

What is your preferred method of contact? (only select one)

☐ E-mail ☐ Mail ☐ Other (Specify) _____
☐ Telephone ☐ Text Message

If you are receiving Long-Term Care services, please select your provider (only one) below:

☐ Include, Respect, I Self-Direct (IRIS)
☐ Managed Care Organization (MCO)
☐ Wisconsin County Development Disability
☐ Wisconsin County Mental Health

Program Name:

Program Contact Name:

Program Contact Phone Number:

Program Contact E-mail Address:

Is there someone you want included in the scheduling of appointments during the referral/application process due to your disability? Please provide contact information below for the person.

Appointment Contact Name:

Appointment Contact Relationship:

Appointment Contact Phone Number:

Appointment Contact Email Address:

Accommodation/Foreign Language Needs (check all that apply)

- ☐ ASL Interpreter
- ☐ Audio Taped Communications
- ☐ Braille
- ☐ Hmong
- ☐ Large Print
- ☐ Other (Specify) _____
- ☐ Spanish

Comments:

Guardian Name (if under 18 or court appointed)	Guardian Phone Number

Guardian Address (Including Agency, City, State, & Zip Code)

Guardian E-mail Address

Guardian Preferred Method of Contact

☐ E-mail ☐ Mail ☐ Text Message ☐ Telephone

Disability (check all that apply)

- ☐ AIDS/HIV
- ☐ Alcohol or Other Drug Disorder
- ☐ Amputation
- ☐ Arthritis
- ☐ Attention Deficit Disorder
- ☐ Autism
- ☐ Back Injury
- ☐ Blind
- ☐ Brain Injury
- ☐ Cancer
- ☐ Carpal Tunnel (Repetitive Use Syndrome)
- ☐ Cerebral Palsy (CP)
- ☐ Cognitive Disability
- ☐ Cystic Fibrosis
- ☐ Deaf
- ☐ Deaf-Blind
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hard of Hearing
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hip/Knee/Other Joint Dysfunction
- ☐ Kidney Failure
- ☐ Mental Illness
- ☐ Missing or Deformed Limb
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myofascial Disorder
- ☐ Paraplegia or Quadriplegia
- ☐ Post Traumatic Stress Disorder
- ☐ Respiratory/Pulmonary/Allergies
- ☐ Specific Learning Disability
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Visual Impairment
- ☐ Other (Specify) _____
- ☐ Unknown (Specify) _____

Describe how your disability impacts your ability to find a job, keep a job, or get a better job:

Gender

☐ Male ☐ Female ☐ Agender ☐ Genderqueer ☐ Nonbinary ☐ Transgender Man
☐ Transgender Woman ☐ Two-Spirit ☐ My gender is not listed ☐ Choose Not to Identify

Pronouns

☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Zirs ☐ Prefer Not to Answer
☐ Other: _____

Race (check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Choose Not to Identify

Ethnicity – Are you Hispanic or Latino?

☐ Yes ☐ No ☐ Choose Not to Identify

How did you hear about DVR? (only select one)

☐ Self-Referral, Friends, Family
☐ 14(c) Certificate Holders/Sheltered Workshops
☐ American Indian VR Services Program
☐ Centers for Independent Living
☐ Service Providers
☐ Adult, Dislocated Worker, and Youth Programs (Title I of WIOA)
☐ Adult Education and Family Literacy Act Program (Title II of WIOA)
☐ Wagner-Peyser Act Employment Service Program (Title III of WIOA)
☐ Other American Job Center or Workforce Development Programs
☐ Elementary and Secondary Schools
☐ Post-Secondary Education Institutions
☐ Employers
☐ Intellectual and Developmental Disabilities Providers
☐ Long Term Support Providers (Family Care, IRIS, Partnership)
☐ Medical Health Provider (Public or Private)
☐ Mental Health Provider (Public or Private)
☐ Social Security Administration
☐ Temporary Assistance for Needy Families (TANF, e.g., W-2)
☐ Veteran's Benefits or Health Administration
☐ Worker's Compensation
☐ Other Sources

Student with a disability (only select one)

☐ Not a Student
☐ Student in middle or high school with a 504 plan
☐ Student in middle or high school with an IEP
☐ Student in middle or high school with no IEP and no 504 plan
☐ Student in postsecondary education or other education program age 21 or younger
☐ Student in postsecondary education or other education program age 22 or older

Name of the School, if Applicable:

Name of School District, if Applicable:

Are you a veteran?

☐ Yes ☐ No

Where are you currently living?

- ☐ Community Residential Facility/Group Home
- ☐ Halfway House
- ☐ Mental Health Facility
- ☐ Substance Abuse Treatment Center
- ☐ Rehabilitation Facility
- ☐ Other
- ☐ Correctional Facility
- ☐ Homeless/Shelter
- ☐ Nursing Home
- ☐ Private Residence (independent, or with family or other person in house, apartment, condo, etc.)

Are you currently receiving any of the following public support? (select all that apply)

SSDI - Social Security Disability Insurance	☐ Yes	☐ No
SSI - Supplemental Security Income for the Aged, Blind or Disabled	☐ Yes	☐ No
TANF - Temporary Assistance for Needy Families (e.g., W-2, Kinship Care, Wisconsin Shares, Caretaker Supplement)	☐ Yes	☐ No
General Assistance – State or Local Government (e.g., county funds, etc.)	☐ Yes	☐ No
Veterans' Disability Benefits	☐ Yes	☐ No
Worker's Compensation (WC)	☐ Yes	☐ No
Unemployment Insurance (UI)	☐ Yes	☐ No
Other Public Support - Public support received from all other services not listed	☐ Yes	☐ No

Are you working? ☐ Yes ☐ No

If yes, where do you work?

Job Title:

Are you receiving medical insurance through any of the following services? (select all that apply)

Medicaid/BadgerCare/MAPP	☐ Yes	☐ No
Medicare	☐ Yes	☐ No
State or Federal Affordable Care Act Exchange	☐ Yes	☐ No
Public From Other Sources	☐ Yes	☐ No
Private Through Employer	☐ Yes	☐ No
Private Insurance Through Other Means	☐ Yes	☐ No
Not Eligible for Private Ins. through current employer, but will be eligible after a period of employment	☐ Yes	☐ No

☐ If this referral is being completed by someone other than the individual or their guardian, you must have their consent. Please check this box as confirmation of consent.

Relationship (only select one)

- ☐ Guardian
- ☐ Educational Institution
- ☐ Family Member
- ☐ Long-Term Care Agency
- ☐ Friend
- ☐ Social Service Agency
- ☐ Other (Specify) _____

Name:

For DVR Office Use Only	
Date Received	DVR Staff Member
DVR Referral Facilitator	

DWD is an equal opportunity employer and service provider. If you have a disability and need assistance with this information, please dial 7-1-1 for Wisconsin Relay Service. Please contact the Division of Vocational Rehabilitation at (800) 442-3477 to request information in an alternate format, including translated to another language