Assistive Technology / Medical Rehab Services

Referral Form

Referring Agency:
Referring Name:
Address:
Telephone:
Date of Referral:
VRCC (if Applicable):

Applicant Information

Name: **Soc Sec Number:** **Date of Birth:**

Address: **City** **State:** **Zip:**

Phone Number: **Alt Phone Number:** **Email:**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Sex:** ☐ **Male** ☐ **Female**

Ethnicity: ☐ **African American** ☐ **Asian American** ☐ **Caucasian** ☐ **Hispanic** ☐ **Native American**
☐ **Multiple Ethnicity** ☐ **Other** _____

Benefits receiving and amount:

Has applicant previously received vocational rehabilitation services? ☐ **Yes** ☐ **No**

If so, when and where?

Housing arrangement: ☐ **Independent** ☐ **With parents** ☐ **Residential (name of facility)**

Transportation: ☐ **Car** ☐ **Bus** ☐ **Dependent** ☐ **Open Door**

Education (last grade completed):

Date last employed: **Salary:** **Position:**

Special skills:

Does applicant have a legal guardian? ☐ **Yes** ☐ **No** **If yes, please provide the following:**

Name: **Relationship to Applicant:**

Address **Phone Number:**

Please check services needed

Assistive Technology

- ☐ **Assistive Technology**
- ☐ **Augmentative Communication**
- ☐ **Workplace Accommodation**

Medical Rehabilitation Services

- ☐ **Driver Evaluation & Training**
- ☐ **Home Modification/Assessment**

What is the nature of the person's disability?

Are there any specific questions or issues that need to be addressed?

What is his/her planned employment outcome?

Additional Information:

4740 Kingsway Drive, Indianapolis, IN 46205 - p/317.466.1000 - f/317.466.2000 - www.eastersealscrossroads.org