

Referral for DVR Services

**Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
 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?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
What is your preferred method of contact? (only select one)				
<input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Telephone <input type="checkbox"/> Other (Specify) _____				
If you are receiving Long-Term Care services, please select your provider (only one) below:				
<input type="checkbox"/> Include, Respect, I Self-Direct (IRIS) <input type="checkbox"/> Managed Care Organization (MCO) <input type="checkbox"/> Wisconsin County Development Disability <input type="checkbox"/> 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)

- | | |
|------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> ASL Interpreter | <input type="checkbox"/> Audio Taped Communications |
| <input type="checkbox"/> Braille | <input type="checkbox"/> Hmong |
| <input type="checkbox"/> Large Print | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> 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

Disability (check all that apply)

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

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

Gender

- Male Female Choose Not to Identify

Race (check all that apply)

- | | | |
|-----------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> 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 (AIVRS)
- 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 Disability Agencies
- Long Term Support Providers (Family Care, IRIS, Partnership)
- Medical Health Providers
- Mental Health Providers
- 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?

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

Are you currently receiving any of the following public support? (select all that apply)	
SSDI - Social Security Disability Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
SSI - Supplemental Security Income for the Aged, Blind or Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No
TANF - Temporary Assistance for Needy Families (e.g., W-2, Kinship Care, Wisconsin Shares, Caretaker Supplement)	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Assistance – State or Local Government (e.g., county funds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Veterans' Disability Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation (WC)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment Insurance (UI)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Public Support - Public support received from all other services not listed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you working? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No
State or Federal Affordable Care Act Exchange	<input type="checkbox"/> Yes <input type="checkbox"/> No
Public From Other Sources	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Through Employer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Insurance Through Other Means	<input type="checkbox"/> Yes <input type="checkbox"/> No
Not Eligible for Private Ins. through current employer, but will be eligible after a period of employment	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 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)	
<input type="checkbox"/> Guardian	<input type="checkbox"/> Educational Institution
<input type="checkbox"/> Family Member	<input type="checkbox"/> Long-Term Care Agency
<input type="checkbox"/> Friend	<input type="checkbox"/> Social Service Agency
<input type="checkbox"/> 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.

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