Department of Workforce Development
Division of Vocational Rehabilitation

State of Wisconsin

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Potentially Eligible (PE) Request

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?

☐ Yes ☐ No

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

☐ E-Mail ☐ Mail
☐ Telephone ☐ Other (Specify)

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

Comments:

Gender

☐ Male ☐ Female ☐ Choose Not to Identify

Race (check all that apply)

☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Ethnicity – Are you Hispanic or Latino?

☐ Yes ☐ No

The student would like to learn more about the following Pre-ETS:

☐ Job exploration counseling

☐ Work-based learning experiences

☐ Workplace readiness training to develop social skills and independent living

☐ Instruction in self-advocacy, including instruction in person-centered planning and peer mentoring

☐ Counseling on opportunities for enrollment in comprehensive transition/postsecondary educational programs

Verification of a disability (documentation may be needed and requested for the provision of services):

☐ High School Student with an IEP ☐ High School Student with a disability but no 504 plan or IEP

☐ High School Student with a 504 plan ☐ Postsecondary Student with a disability

School name: District Name:

Section to be completed by the student or legal guardian

This signature below confirms permission and/or intent to participate in Pre-ETS services.

Guardian Name (if under 18 or court appointed)	Guardian Phone Number
Guardian Address (Including Agency, City, State, & Zip Code)	
Guardian E-Mail Address	
Student Signature (or Guardian Signature if under 18 or court appointed)	**Date Signed**

Section to be completed by referring educational agency- if applicable

Educational Agency Name	Educational Agency Phone

As a representative of the referring educational agency identified above, I certify the following:

1. All the information and statements provided in Section I are true and correct to the best of my knowledge.
2. The existence and availability of documentation supporting items checked in the verification of disability section.

Representative Name (Please Print)

Representative Signature	Date Signed

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.

DVR-18207 (R. 06/2019)