New Jersey
Division of Vocational Rehabilitation Services

Confidential Referral Form

Vocational Rehabilitation Agencies assist individuals with disabilities to prepare for, obtain and/or keep suitable jobs. The rehabilitation services the agency can provide depend on the availability of State and Federal funds and on the availability of other programs and services. All individuals have the responsibility to: participate financially in their plan to the best of their ability; obtain services only with prior written approval; cooperate by using community services when they can be of help in the rehabilitation program; maintain regular contact with the VR agency counselor; and, go to work when the VR program is completed.

Name____ Date______/______/________

Address____ County____________________

City______________________________ NJ Zip______________ Telephone Number(   )_______-_________

Social Security Number_________-________-__________ E-Mail__________________________________

Disability____

Birth date_____/_____/_______ Age ____ Sex ____ Marital Status_____ Veteran (Y or N)______

English Speaking (Y or N) ______ Spanish Speaking (Y or N) _______ Other Language:______________

ANY HEARING LOSS: (Y or N) Sign Language (Y or N) ______ Cochlear Implant: (Y or N)

Have you ever applied to DVRS before (Y or N)_________ If yes, when/where_________________________

Highest grade completed in school? __________________________

Do you receive any Public Assistance? (Check all that apply)

SSD __ SSI __Food Stamps __ Sec-8/Rental Assistance __ TANF-Case # ____________ General Assist-Case # ____________

Name of Case Worker____________________________________ Phone # (   ) __________-_______________

Referral Source:

Name____________________________________ Phone Number (   ) __________-_____________

Agency___________________________________ E-Mail ____________________________________

Address__________________________________ City/State/Zip ______________________________

Reason for referral:____

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***If records documenting disability are available, please include with referral to expedite eligibility process.

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(BELOW FOR DVR OFFICE USE ONLY)

Assigned to Counselor _______ or Walk-In Assigned to COD ______ Date: _____/_______/______

Appointment Date & Time____

OO Closure Date: ____________________ Reason: ____

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(Revised 3/13/2007)