VOCATIONAL REHABILITATION
REFERRAL FORM
EMPLOYMENT AND COMMUNITY FIRST CHOICES

ECF CHOICES Member Information:

First Name:	Middle Name:	Last Name:

Date of Birth:	--Click here to enter a date--	Age:	
Gender:	--Male/Female--	SSN:	

Street Address:		
	Suite/Apt #:	

City:	State:	Zip Code:	County:

Main Residence?	--Yes/No--	Mailing Address?	--Yes/No--
Home Phone:	Cell:		Alt Phone:

TTY:		Email:	
Preferred Method of Contact:	--Choose One--		

Primary Language:	Other Language:
Manual Communication Mode:	Preferred Written Communication Medium:

Transportation & Mobility (Choose all that apply):

☐ w/Cane ☐ w/White Cane ☐ w/Assistive Devices

☐ w/Wheelchair ☐ on Public Transportation ☐ Other

Email completed form and supporting documentation to local VR office

Representative's Information:

First Name:		Last Name:	

Lives with Applicant?	--Yes/No--

Street Address:		
	Suite/Apt #:	

City:	State:	Zip Code:	County:

Home Phone:	Cell:	Alt Phone:

TTY:	Email:	
Relationship:	Legal Guardian?	--Yes/No--
	Receive Mail?	--Yes/No--

Support Coordinator Information:

First Name:		Last Name:	
MCO:			
Phone:		Email:	

SHARED DOCUMENTATION CHECKLIST
☐ Comprehensive Needs Assessment
☐ Person-Centered Support Plan
☐ Disability Documentation
☐ ECF CHOICES employment service report(s) (if applicable)
☐ Guardianship Documents (if applicable)
☐ Release of Confidential Information
The documents checked above are being submitted with the VR Referral Form.

ECF CHOICES Support Coordinator (Print Name):	**Signature:**
Date: --Click here to enter a date--	

This section is to be completed by VR Program Office ONLY:
☐ The ECF CHOICES Member listed above is **ELIGIBLE** for the VR Program. **Date:**
☐ The ECF CHOICES Member listed above is **INELIGIBLE** for the VR Program. **Date:**
Once this section is completed, VR Office should submit copy to MCO Support Coordinator.

Email completed form and supporting documentation to local VR office