Iowa Vocational Rehabilitation Services
Finding solutions. Generating success.

Iowa Vocational Rehabilitation Services
Referral/Application for Services

IowaWORKS
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Please complete all sections. If you would like assistance with this form, do not hesitate to ask. If you need more space, please use an additional piece of paper. You may also submit this information online at https://ivrs.iowa.gov/agency-services/apply-services.

Please check one:

❑ I, or the individual I am referring, is **considered legally blind or has a specific low vision impairment** that presents difficulty in preparing for, obtaining, or maintaining employment. If this situation applies, **STOP** completing this form and **contact the Iowa Department for the Blind at 515-281-1333** for vocational rehabilitation services. Iowa Vocational Rehabilitation Services is not allowed to work with individuals in this population.

❑ I am **referring** the individual listed in the next section for Iowa Vocational Rehabilitation Services. Please enter your contact information below.

Name: _____ Phone: _____ E-Mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to referred individual listed below: _____

Reason for referral/anticipated service needs/other comments? _____

_____

Is the individual listed below currently working in subminimum wage employment or considering work at subminimum wage? ❑ No ❑ Yes

❑ I am the individual listed below. **I would like to learn more about vocational rehabilitation services**, **but I'm not sure whether I want to apply at this time.** (Upon receipt of this form, you will be contacted by IVRS to provide more information.)

❑ I am the individual listed below and **I wish to apply for vocational rehabilitation services**. (Upon receipt of this form, you will be contacted by IVRS to schedule an intake appointment.)

Referral/Applicant's Personal Information:

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____ Maiden or Other Names Used: _____

Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Primary E-Mail: _____ Secondary E-Mail: _____

Preferred Method of Communication: ❑E-mail ❑Phone ❑Video Relay ❑Letter

May IVRS send text messages? ❑No ❑Yes

Social Security Number: _____ Date of Birth: _____ Age: _____

Do you require an interpreter? ❑No ❑Yes Language: _____

Contact Information:

Provide information for one or two people who will be able to help us contact you.

First Name:_____ Last Name:_____ Relationship: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

First Name:_____ Last Name:_____ Relationship: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

Do you have a **Court-appointed** legal guardian? ❑ No ❑ Yes (If Yes, provide information below.)

Name: _____
Phone: _____ E-Mail: _____
Address:_____ City: _____ State: _____ Zip:_____

STOP HERE--Please send the form to your local IVRS office.

Please bring the following information to the appointment:

Copies of Documents Necessary to Comply With Form I-9, Employment Eligibility Verification.
Driver's License, Social Security Card, Passport, Work VISA, School Record (high school students), etc.

Information about Your Disability
When it started and how it affects your ability to work.

Information about Any Treatment, Past or Present
Medical reports already in your possession, names and addresses of doctors, hospitals, clinics, etc.

Information about Your Education
Names and dates of attendance of high school, college, or vocational schools, etc. Bring grade reports or transcripts if available.

Information about Any Jobs You Have Held
Summary of any work you have done and a copy of your résumé, if you have one

Information about Other Services You Receive
Public Assistance, Social Security Benefits--proof of SSI, SSDI benefit (i.e. check stub, letter of eligibility, etc.), Family Investment Plan (FIP), etc.

IVRS USE ONLY:

Source of Referral

- ❑ 14(c) Certificate Holders
- ❑ Adult Education and Literacy Programs
- ❑ American Indian VR Services Program
- ❑ Centers for Independent Living
- ❑ Service Providers including CRPs
- ❑ DOL Adult, Dislocated Worker, and Youth Program
- ❑ Elementary/Secondary Schools
- ❑ Post-secondary Educational Institutions
- ❑ Employers
- ❑ Extended Employment Providers
- ❑ Intellectual and Developmental Disabilities Providers
- ❑ Managed Care Organizations (MCOs)
- ❑ Medical Health Provider
- ❑ Mental Health Provider
- ❑ Self-referral, friends or family
- ❑ Social Security Administration
- ❑ Temporary Assistance for Needy Families (TANF)
- ❑ Veteran's Benefits or Health Administration
- ❑ Wagner-Peyser Employment Service Program
- ❑ Worker's Compensation
- ❑ Other Sources
- ❑ Other AJC/Workforce Development Programs

Date Received by IVRS: _____