The University of the State of New York
THE STATE EDUCATION DEPARTMENT
The Office of Adult Career and Continuing Education Services-Vocational Rehabilitation
(ACCES-VR)

Referral to ACCES-VR for Supported Employment

Print or type District Office mailing address below

Program Contact Person
Last First
_____

SE Program
_____

SE Mailing Address

Area Code & Phone Number
( ) ____ - _____

Referral Date ____ - ____ - ____

Consumer Information

Name: Last First Middle Initial
_____

Phone Number: Home ( ) ____ - ____ Other ( ) ____ - ____

Address: Street City State Zip Code
_____

Social Security Number (optional) ___ - ___ - ___ Date of Birth: ___ / ___ / ____

Intensive Contract Number	**Projected Extended Services Provider Name**
List all Physical or Mental Disabilities that Results in a Functional Limitation – That You Will Describe Below	
Functional Limitation (Check Three or More. Supporting Documentation must be Attached for Each Checked Box	**Describe the Vocationally Significant Impairment for Each Checked Box**
Communication	
Interpersonal	
Mobility	
Self Care	
Self Direction	
Work Skills	
Work Tolerance	

Relevant Educational / Vocational History
Explain What Prevents the Individual from Maintaining Employment Without Ongoing Supports
Current Vocational Interests
Suggested Vocational Goal
Health Information (Including Medications)
Attitudinal, Behavioral, and Environmental Factors
Assistive Devices, Transportation, and ADL Needs
Other Concurrent Services or Treatment
Please List Reports Attached