Vocational Rehabilitation

Pre-ETS Referral Form

*Required Fields

Student Information

*Name: _____ SS#: _____

*Date of Birth: _____ Gender: _____ Disability Documentation: _____

Race: _____ Ethnicity: _____

*Home address: _____

*City: _____ *Zip Code: _____ *County: _____

*Phone Number: _____ Email: _____

*Name of School: _____

Parent/Guardian Information (if applicable) Name: _____

Home Phone, if different from student: _____ Cell: _____

Email: _____

*Agency Making Referral

Name: Michael Hearts Academy, Inc Position: Director

Email: Mjhearts19@gmail.com Phone: 407-223-0949

Accommodations for initial meeting with VR Staff:

Do you require an American Sign Language interpreter? ☐ Yes
Do you require an assistive listening device? ☐ Yes
Do you required translated documents? ☐ Yes
Do you require a foreign language interpreter? ☐ Yes
Do you require any other accommodation for your impairment? ☐ Yes
If yes, please explain: _____

*Transition Youth Services Requested (Check all that apply)

☐ Job Exploration Counseling (includes discussions on the student's vocational interests, the labor market, and identification of career pathways)

☐ Work Readiness Training (A 20 hour course that focuses on employability and work readiness skills)

☐ Self-Advocacy Training (A course that teaches students how to speak up for themselves and make decisions about their own lives)

☐ Postsecondary Educational Counseling (provides an awareness of post-secondary career pathway options with job and career information) * Service is not currently available

☐ Work-Based Learning Experiences (includes hands on training for employability skills; may be paid or non-paid)

Student Acknowledgement

I understand that through Vocational Rehabilitation, I will be offered limited Pre-Employment Transition Services that can help me explore, prepare for, and make informed career-based decisions. I understand that I must be an active participant in the services I choose to achieve my transition goals.

_____ _____
Signature of Student Date

Permission to Make Referral

By Signing this Pre-ETS Referral, I give Michael Hearts Academy, Inc **permission to submit this Pre-ETS Referral to VR. I understand I will be contacted by VR Staff to set up an initial meeting and acknowledge that my participation is required if my child is under 18 or if I am his/her Guardian.**

Parent/Guardian/Age of Majority Student: _____ _____
Signature Date

Referral Staff: Jennifer Biggins Director
Printed Name Position

Jennifer Biggins _____
Signature Date

Name of person submitting the Pre-ETS Referral to VR: Jennifer Biggins **Phone # of person submitting the referral to VR (if different):** 407-223-0949

For Official VR Use Only (to be completed by VR Staff)

VR Staff Name: _____ Area/Unit_____

Date referral received: _____ Date entered into RIMS: _____