Greetings,

Thank you for your recent inquiry about receiving services from the Department on Disability Services / Rehabilitation Services Administration (DDS/RSA). DDS/RSA provides youth transition services, including Pre-Employment Transition Services (Pre-ETS), and Vocational Rehabilitation Services (VR), for DC students with disabilities, ages 14-22. Enclosed is the:

- **Pre-Employment Transition Services (Pre-ETS) Consent Form** (page 2), and
- **Vocational Rehabilitation (VR) Referral Form** (pages 3-5).

Please complete the attached Pre-ETS Consent Form. If you also wish to apply for VR Services, please continue to page 3 and complete the VR Referral Form. A completed VR Referral Form will express your interest in pursuing VR services with DDS/RSA. If you need assistance, please contact Beverly Cummings or Tania Benton at 202-442-8675 / RSA.Transition@dc.gov.

In addition to the VR Referral Form, DDS/RSA will request copies of the following documents for all individuals who want to apply for VR services:

- **Psychological Evaluation** (Must be completed within last 3 years)
- **Proof of School Enrollment** (Official School Transcript, Report Card)
- **Government Issued Photo ID** (DC One Card, Driver’s License, State ID card)
- **Social Security Card**
- **Supporting Documentation**: School Records (IEP/504 Plan), Medical Records, or Social History report that demonstrates the presence of a medically diagnosed disability

If you need assistance collecting any of the required school records or supporting documentation, please contact your Local Education Agency or Special Education Coordinator at your school. Completed Pre-ETS Consent Forms and/or VR Referrals Forms should be scanned/emailed to RSA.Transition@dc.gov. **Do Not** send any documents in the mail. Copies of original documentation can be brought to your initial Intake Interview at your school. Intake is scheduled upon receipt and review of completed VR Referral Form.

This agency is proud, ready, and willing to assist you in reaching your employment goals. Thank you for your interest in the Department on Disability Services.

Sincerely,

/s/ Angela M. Spinella (signed electronically)

Angela M. Spinella  
Program Manager  
Rehabilitation Services Administration
VOCATIONAL REHABILITATION (VR) REFERRAL FORM

Today’s Date: ______________________________

Last Name: ___________________________ First Name: ___________________ MI: ______

Street Address: _______________________________________________________________

City, State: ___________________________ Zip Code: ______________ Ward: ______

Telephone Number: (____) ___________ Secondary No. (____) ___________

Email Address: ______________________________________________________________

Social Security Number: _______ - ______ - _______ Gender: [□] Male [□] Female

Date of Birth: Month ___ Day ___ Year __________ Current Age: ______

Are you currently working? [□] Yes [□] No

Name of School: _____________________________________________________________

What is your disability? ______________________________________________________

Do you require special accommodations for appointments? [□] Yes [□] No

If yes, what? __________________________________________________________________

Are you currently receiving any of the following benefits? Please check all that apply:

[□] SSI/SSDI [□] Unemployment [□] Interim Disability Assistance (IDA)

[□] Food stamps [□] Survivor benefits [□] Child support

[□] Other: __________________________________________________________________

Referral Source (School / Site Name): ___________________________________________

Referral Address: ____________________________________________________________

Referral Name & Telephone Number: ___________________________/ Ph: (____) ______

If English is not your language of preference, is it: [□] Spanish [□] ASL [□] Other ______

** This form is for referral purposes only. No additional information is required, but is helpful in expediting your eligibility. This is neither an application, nor a request for vocational rehabilitation services. If under 18 years old, a parent/guardian must sign.

Parent/Guardian Signature ___________________________________________ Date __________

__________
WAIVER OF CONFIDENTIALITY

Last Name:            First Name:        MI:

SSN:

The above named individual has been referred to the DC Department on Disability Services’ Vocational Rehabilitation Program. I understand that in order to determine eligibility and services necessary to achieve a vocational goal, a comprehensive evaluation may be required. My signature authorizes the DC Department on Disability Services to conduct such an evaluation including medical, mental health, psychological, and/or vocational assessments.

Authorization is also granted to the DC Department on Disability Services, Developmental Disability Administration (DDA) and Rehabilitation Services Administration (RSA), to release and share information regarding the above named individual in order to determine eligibility for services, and in order for the two administrations to effectively coordinate any on-going services which the individual may receive.

I understand that granting this consent and waiver of confidentiality for the above stated purpose(s) is voluntary on my part and may be revoked at any time.

___________________________________________  _________________
Client's Signature                       Date

___________________________________________  _________________
Parent/Guardian's Signature              Date
CHECKLIST (FOR REFERRAL SOURCE TO COMPLETE)

Additional Student Information

Is the student in Foster Care: Yes  No
Is the student Court Sponsored: Yes  No

If answer is Yes to either question, please provide specific program information below:

Program Name: ________________________________________________________________
Contact person: ________________________________________________________________
Title: ________________________________________________________________________
Address: _____________________________________________________________________
Phone Number: __________________________________________________________________
Email Address: __________________________________________________________________

The required documentation to determine eligibility for DDS/RSA services is listed below. Please indicate if any of the following are included with the VR Referral Form.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>Type of Information</th>
<th>Examples</th>
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<tbody>
<tr>
<td></td>
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<td>Current and relevant reports describing disability, functional capacity, independent living skills and student support needs</td>
<td>Medical and/or health screening; Licensed Specialist's disability assessment; Psychological / Psychiatric assessment</td>
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<td>Transition planning and student services reports</td>
<td>Current IEP or 504 Plan; Records of Transition Planning Meetings;</td>
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<td>Career development</td>
<td>Vocational assessments/reports; Work supervisor evaluations; History of prior work experience; Work-study progress reports; Resume</td>
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<td>Academic Achievement</td>
<td>Educational Evaluations; Current transcript; Report Cards; Academic achievement testing; Reports of college study skills readiness</td>
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<td>Attendance Pattern</td>
<td>Attendance Report</td>
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</tbody>
</table>

Special Notes: ________________________________________________________________

**Completed referrals for DCPS students should be emailed to DCPS.Transition@k12.dc.gov.**

Completed Referrals should be scanned/ emailed to RSA.Transition@dc.gov. Thank you.