[Company Name]

Referral Information for VR

# Applicant INformation

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date  |  |
| Phone |  | Upload Photo if applicable |  |
|  Email |  |  |  |
|  Guardian |  |  |  |
| AddressCity, State ZIP Code |  |  |  |

# Continued

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security Number |  | Date of Birth |  |
|  Gender |  | Ethnicity |  |
|  Primary Disability |  |  Secondary Disability |  |
|  Other Medical Concerns |  | Other Medical Concerns |  |
| Has Proof of Disability |  | Type of Documentation |  |

# Additional Contacts

|  |  |  |  |
| --- | --- | --- | --- |
|  Case Manager |  | Phone |  |
| Address |  | Fax |  |
| City, State ZIP Code |  | E-mail |  |
| Agency Name |  | Other |  |
| Residential |  | Phone |  |
| Address |  | Fax |  |
| City, State ZIP Code |  | E-mail |  |
| Agency Name |  | Other |  |
| Guardian |  | Phone |  |
| Address |  | Fax |  |
| City, State ZIP Code |  | E-mail |  |
| Relation to applicant |  | Other |  |

# Required Documents

1. Proof of Disability (Medical/ Educational/ Support Plan Records)
2. Signed Release Form
3. VR Experience Records/Reports and Documentation

# SIGNATURES

|  |  |  |  |
| --- | --- | --- | --- |
|  Applicant |  | Guardian |  |
| Date |  | Date |  |

# Process

|  |  |  |  |
| --- | --- | --- | --- |
|  Agency InformationCompany |  | Name |  |
| Phone |  | Email |  |

Save a copy of this form for your records.

Email to: smwage@vr.dese.mo.gov