State of Kansas
Department for Children and Families
Economic and Employment Services

IS-4308
Rev. 07-17

Assessment Referral

DCF Referring Office: _____
Address: _____
Case Manager Name: _____
Case Manager Phone: _____

Provider Name: _____
Provider Address: _____

Client Name: _____
Phone Number: _____
SSN: _____
Date of Birth: _____ Gender: _____
Case #: _____
Medical ID#: _____

This person is being referred to you for more information regarding his/her ability to work or participate in work-related activities. Please bill the local DCF office at the address listed above, **Attention:** _____.

This referral is for:

___ Vocational Assessment
___ Psychological Evaluation
___ Psychological Evaluation with LD Evaluation
___ LD Evaluation
___ Medical Resolution
___ Other _____
___ Other _____

I have included records from:

___ Vocational Assessment/CDC dated _____
___ Psychological Evaluation
___ Psychological Evaluation with LD Evaluation
___ LD Information
___ Medical Providers
___ Definitive Medical Report
___ CASAS Appraisal/Diagnostic Results
___ SASSI Results
___ EES Initial Assessment Information
___ Other _____

REPORT: The intent of this referral is to help identify work options and specific plans to achieve those options. Include all applicable results in your response, including tools used, functional limitations and capabilities, vocational options, specific accommodations to maximize ability to work, local labor market options, transferable work skills, referral to other services, and specific recommendations. In addition, please address the following questions, if applicable.

1 .

2.

3.

Case Manager Signature: _____ **Date of Referral:** _____
cc: case file

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and/or disclosure of my health information as described below.

Name of the person or organization authorized to ***provide*** the information:

Name, address and telephone number of the person or organization authorized to ***receive*** and use the information:

Describe specifically and meaningfully the information to be released (include dates of service where applicable):

Describe the purpose for the request to release information (use "N/A" to decline to describe the purpose for the release):

This authorization will expire when my DCF assistance case closes.

I understand that I have the right to revoke the authorization by delivering such revocation in writing to _____ releasing agency or other entity making the disclosure except to the extent that the agency or entity has already released the information.

Once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

The _____ releasing agency will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.
I certify that I agree to the uses and disclosures listed above and that I will receive a copy of this authorization.

_____ _____
Signature Date

_____ _____
Signature of Personal Representative (if applicable) Description of Authority