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

IS-4315
Rev. 05-16

Referral to Rehabilitation Services

Client Information

Name:
_____

Address:
_____

Phone: _____ SSN:_____
DOB: _____ Gender:_____
County: _____ Case#:_____

Referral to RS

EES Case Manager:_____ Date of Referral:_____
Phone:_____ Email:_____

Applicant for the following:
_____ TANF
_____ Food Assistance
_____ Medical
_____ Child Care
_____ SSI
_____ SSDI
Recipient of the following:
_____ TANF$_____
_____ Food Assistance$_____
_____ Medical
_____ Child Care
_____ SSI $_____
_____ SSDI $_____
Status with EES:
_____ Exempt
_____ Mandatory
_____ Voluntary
TANF Months used:_____

Describe the basis of the client's incapacity/disability and attach copies of any available medical, psychological or psychiatric reports. (Such as: TABE, CDC/Vocational Assessment, SASSI, Self-Sufficiency Agreement, LD Information, Medical Providers, Psychological Evaluation, Initial Assessment Information, EES Screening Tool, Definitive Medical Report.) _____
_____
_____
_____
_____
Describe the client's interest in work or their feelings about work: _____
_____
_____
Client has been notified of the Referral:_____

Case Manager Signature:_____
Date:_____

cc: case file