Referral to Rehabilitation Services

Consumer Information

Name: _____
Address: _____
Phone: _____ SSN: _____
DOB: _____ Gender: _____
County: _____ KAECSES #: _____

Referral to RS

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

Applicant for the following:

_____ TAF
_____ GA
_____ Food Stamps
_____ Medical
_____ Child Care
_____ SSI
_____ SSDI

Recipient of the following:

_____ TAF $_____
_____ GA $_____
_____ Food Stamps $_____
_____ Medical
_____ Child Care
_____ SSI $_____
_____ SSDI $_____

Status with EES:

_____ Exempt
_____ Mandatory
_____ Vountary

TAF Months used: _____ GA Months used: _____

Describe the basis of the consumer's incapacity/disability and attach copies of any available medical, psychological or psychiatric reports. (Such as: CAP2, CASAS, CDC/Vocational Assessment, SASSI, Self-Sufficiency Agreement, LD Information, Medical Providers, Psychological Evaluation, Initial Assessment Information, EES Screening Tool, Definitive Medical Report.) _____

_____

_____

_____

_____

Describe the consumer's interest in work or their feelings about work: _____

_____

_____

Consumer has been notified of the Referral: _____

Case Manager Signature: _____ **Date:** _____

cc: case file