State of California--Health and Human Services Agency | Department of Developmental Services

VOCATIONAL SERVICES REFERRAL

DS 1968 (New 4/2004) (Electronic Version)

TYPE OR PRINT LEGIBLY (SEE INSTRUCTION

Estimated Start Date

Consumer Information

SOCIAL SECURITY NUMBER	UCI NUMBER	LAST NAME	FIRST NAME

MAILING ADDRESS	CITY	ZIP	PHONE

CONSERVATOR/PARENT LAST NAME	FIRST NAME	PHONE

MAILING ADDRESS	CITY	ZIP

CURRENT PROGRAM | PRIOR PROGRAM

Consumer Referral Choice ☐ **VR** ☐ **HAB**

PREFERRED PROVIDER NAME

☐ WAP ☐ VR-WAP ☐ SEP-IP ☐ SEP-GP ☐ No Preference at this time

	Required								(Most Recent, if Available)			
REPORTS ATTACHED	☐	CDER	☐	IPP	☐	MED	☐	PSY	☐	SOC		
REPORTS SENT TO VENDOR	☐	CDER	☐	IPP	☐	MED	☐	PSY	☐	SOC		

CERTIFICATION

I certify that according to the Individual Program Plan (IPP) this individual requires vocational services. I am referring this person for services and understand that a determination of initial eligibility to confirm the need for services shall depend on findings from an evaluation. This person is eligible for regional center's habilitation extended services and other vocationally-related services specified in the consumer's IPP.

RC NAME	RC CODE	RC REPRESENTATIVE (PRINT)	RC REPRESENTATIVE (SIGNATURE)	DATE

ADDRESS	CITY	ZIP

PHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS

I understand that in the course of providing vocational services to me, this information will be shared with the Department of Rehabilitation and the applicable service providers. I agree to have the regional center pay for the services that may result from this referral.

CONSUMER'S SIGNATURE	CONSERVATOR'S SIGNATURE	DATE

WITNESS NAME (IF NECESSARY)	WITNESS' SIGNATURE (IF NECESSAR	DATE

NOTICE

The information provided in these documents is protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). Reasonable and appropriate safeguards must be implemented to protect the confidentiality and integrity of this information in any format as well as during transmission in electronic format as applicable.

The Department of Developmental Services affirmatively supports all federal and state civil rights laws and will not knowingly do business with any agency or entity which discriminates on the basis of ethnic group, sexual orientation, physical or mental disability, medical condition, marital status or ancestry.

If referral is for VR, distribution is: **ORIGINAL** - VR Office **COPY 1** - Regional Center File
COPY 2 - VR/HAB Services Provider **COPY 3** - Consumer

If referral is directly to a Habilitation WAP vendor, distribution is: **Original** - Habilitation service provider
Copy 1 - Regional Center file **Copy 2** - Consumer