



# Referral for Extended Employment Services (EES)

To: **Extended Employment Services Specialists**

From: \_\_\_\_\_ (VRC name)

Date: \_\_\_\_\_ (this will be the referral date to EES)

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**Extended Employment Category**  DD  MH  SLD  TBI

Please attach medical and/or psychological reports, any other relevant information or a narrative summary and a signed release from client.

### Service Requested (estimated)

- Work Services \_\_\_\_\_ hours per **week**
- Transportation (primarily for Work Services) \_\_\_\_\_ units (trips or days) per **week**
- CSE/DD \_\_\_\_\_ hours per **Month** Estimated maintenance date: \_\_\_\_\_
- CSE/MH \_\_\_\_\_ hours per **Month** Estimated maintenance date: \_\_\_\_\_

### Additional Helpful Information

**Developmental Disabilities:** Targeted Service Coordination  Yes  No  Unknown

Service Coordination Agency: \_\_\_\_\_ Service Coordinator's Name: \_\_\_\_\_

DD Eligibility:  previously established  in process (has been referred)  
 has not applied for services  unknown

Receiving other DD Services  Yes  No  Unknown

Eligible for HCBS waiver  Yes  No  Unknown

**Mental Health:** ACT Team Client  Yes  No MH Case Management (private)  Yes  No

Agency: \_\_\_\_\_ Case Manager Name: \_\_\_\_\_

Client preference for CRP: \_\_\_\_\_

### (The following information to be filled out by an EESS)

Received by EESS: \_\_\_\_\_ (date) Entered into database: \_\_\_\_\_ (date)

Eligibility confirmed: \_\_\_\_\_ (date) by: \_\_\_\_\_ (EESS)

Budget assigned: \_\_\_\_\_ (date) \_\_\_\_\_ (annual amount)

Notice sent to VRC:  Notice sent to CRP:  Plan received from CRP: