Kansas
Department for Children and Families
Rehabilitation Services

4/2/2019

West Region High School Referral for Pre-Employment Transition Services

Please send completed referral to Ashley Merz **Ashley.Merz@ks.gov** *or fax 785-493-8003*

To be completed by high school

From: School _____

Address/County _____

School District#/Building Name _____

Phone _____

Name/Position Title _____

Email Address _____

Student: Name _____

Address _____

City/State/Zip Code _____

County _____

Phone _____

Birth Date _____

Expected Date to complete or exit high school _____

Referral Accompanied by: Signed release of information ☐ and IEP ☐ or 504 Plan ☐

To be completed by Student, Parent/Legal Guardian (if applicable)

Best time to schedule a meeting: _____

Pre-Employment Transition Services:
Which services are you interested in?

_____ Job exploration counseling

_____ Work-Based Learning Experiences

_____ Instruction on self-advocacy

_____ Counseling on opportunities for enrollment in comprehensive transition or postsecondary education programs

_____ Workplace readiness training to develop social skills and independent living skills

Consent for referral/release of information on back of page, please review and sign

Not an application for Vocational Rehabilitation (VR) Services

CONSENT FOR REFERRAL/RELEASE OF INFORMATION

Below is the signature authorization for _____ to be referred for Pre-Employment Transition Services (Pre-ETS), Program of Kansas Rehabilitation Services (RS) with the Department for Children and Families (DCF). I consent to the release of the information about me to be sent to RS for purposes of Pre-ETS and the school to discuss planning and service delivery.

Signature of Student _____Date_____

Signature of Parent/Legal Guardian _____ Date_____

Print Name of Parent/Legal Guardian _____

If signed by parent/legal guardian (if applicable), please provide address and phone number if different than the student's.

Address: _____

Phone: _____

Email: _____

Auxiliary Aids needed: _____

(Examples: Braille, Large Print, Sign Language Interpreter)

Kansas
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Request for Pre-Employment Transition Services
(Pre-ETS)

Please note: This is not an application for Vocational Rehabilitation (VR) Services.

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ SOCIAL SECURITY NUMBER _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ PHONE NUMBER _____ CELL PHONE NUMBER _____ COUNTY OF RESIDENCE _____

STUDENT EMAIL ADDRESS _____ EXPECTED DATE TO COMPLETE OR EXIT HIGHSCHOOL _____ CURRENT GRADE LEVEL OF EDUCATION _____

GENDER	**SCHOOL DISTRICT #**	**WHAT SCHOOL DO YOU ATTEND?**	**DESCRIBE YOUR DISABILITY**	**DO YOU NEED AUXILIARY AIDS FOR PARTICIPATION IN PRE-ETS?**
_____ MALE _____ FEMALE	(WRITE BELOW) _____	(WRITE BELOW) _____	(WRITE BELOW) _____	(IF YES, DESCRIBE BELOW) _____

CRITERIA
(CHECK YES OR NO)

THE STUDENT IS ELIGIBLE FOR, AND RECEIVING SERVICES UNDER IEP.
_____ YES
_____ NO

THE STUDENT WHO IS AN INDIVIDUAL WITH A DISABILITY, FOR PURPOSES OF SECTION 504.
_____ YES
_____ NO

RACE
(CHECK ONE OR MORE)
_____ WHITE
_____ BLACK OR AFRICAN AMERICAN
_____ AMERICAN INDIAN OR ALASKA NATIVE
_____ ASIAN
_____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

ETHNICITY - HISPANIC OR LATINO
(CHECK YES OR NO)
_____ YES
_____ NO

PRE-EMPLOYMENT TRANSITION SERVICES
WHICH SERVICES ARE YOU INTERESTED IN?
_____ JOB EXPLORATION COUNSELING
_____ WORK-BASED LEARNING EXPERIENCES
_____ COUNSELING ON OPPORTUNITIES FOR ENROLLMENT IN COMPREHENSIVE TRANSITION OR POSTSECONDARY EDUCATION PROGRAMS
_____ WORKPLACE READINESS TRAINING TO DEVELOP SOCIAL SKILLS AND INDEPENDENT LIVING SKILLS
_____ INSTRUCTION ON SELF-ADVOCACY

ARE YOU A US CITIZEN? (CHECK YES OR NO)
_____ YES _____ NO
IF NO, DO YOU HAVE AN ALIEN REGISTRATION CARD?
_____ YES _____ NO
IF NO, DO YOU HAVE AN EMPLOYMENT AUTHORIZATION DOCUMENT?
_____ YES _____ NO

THE STUDENT IS CURRENTLY IN CUSTODY OF DCF OR KDOC-JS (JUVENILE SERVICES), TRIBAL CUSTODY OR HAVE AN OPEN DCF INDEPENDENT LIVING CASE?
_____ YES _____ NO

APPLICANT'S SIGNATURE _____ DATE _____

PARENT'S, GUARDIAN'S OR LEGAL REPRESENTATIVE SIGNATURE _____ DATE _____

PRINT PARENT'S, GUARDIAN'S OR LEGAL REPRESENTATIVE NAME _____

PARENT, GUARDIAN, REPRESENTATIVE ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PARENT, GUARDIAN, REPRESENTATIVE PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

Next Steps – Pre-ETS Transition Specialist will schedule an initial meeting with you. It would be helpful to bring a copy of your IEP or 504 plan to this meeting. If you do not have any documents, Pre-ETS will help you figure out options to obtain the necessary information.

Definitions

504
Any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment or (3) is regarded as having such an impairment. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks.

IEP
Individualized Education Plan (IEP)

STATE OF KANSAS
Department For Children and Families - Vocational Rehabilitation (VR)

Release of Information
Authorization for Disclosure to Release and Obtain Private Information

NAME: (Last, First, MI)	SOCIAL SECURITY NUMBER ###-##-	BIRTHDATE

I authorize the disclosure of my private information, as follows:

Disclosure of information from:	Disclosure of information to:
	Vocational Rehabilitation Attn:
Phone: Fax:	Phone: Fax:

The type and amount of information to be disclosed:

- ☐ Medical records including diagnoses, prognoses, treatment plans, medical recommendations, current general health status, medications and employment limitations imposed by disability. This includes, but not limited to general physical exam, visual reports, and audiological evaluations, etc. Limited to medical records from _____ to _____.
- ☐ Drug/alcohol treatment records
- ☐ HIV/AIDS – Related Information
- ☐ Psychiatric/Psychological testing/reports: including DSM V diagnosis, treatment records, clinical notes, discharge summaries & functional limitations to employment.
- ☐ Employment Information and Records including, but not limited to verification of wage earnings, hours, benefits, and performance
- ☐ Vocational information, including vocational evaluations, recommendations, employment barriers, plans, and progress reports.
- ☐ Criminal History Records, current legal system involvement
- ☐ Academic testing/Transcripts/Degree Analysis
- ☐ Educational Records (IEP/504/Behavioral Plan/Schedule)
- ☐ Financial Aid Award Letter
- ☐ Accommodation/Employment Needs
- ☐ Service Record Information
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

☐ **Electronic Information Exchange:** I authorize use of e-mail and/or other electronic devices by VR for exchange of information with me. I understand that there are no security features in place to assure confidentiality.

The information identified above is necessary for: Determination of eligibility, planning, and coordination for rehabilitation services.

Authorization for Disclosure: (A photocopy or fax of this release is as effective as the original):

- I understand the information released by this authorization may include personally identifying information concerning physical and mental disabilities, alcohol/drug abuse, HIV/AIDS, medical history, criminal history, and educational/vocational records.
- I understand the authorization for disclosure allows verbal and written communication to the identified party above.
- I understand that this authorization for disclosure is voluntary. I understand that VR will use the information disclosed for purposes of vocational rehabilitation, and will not be released to any other person, agency, or entity for purpose without my written permission except as required by Federal or State law.
- Parties to whom VR provides information are prohibited under federal regulations (34 CFR 361 and/or 45 CFR Part 2) from further releasing the information without my express written consent. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the party receiving it. I also understand the specific rules governing VR's re-disclosure of information obtained under this release, which are identified in VR's Rights and Responsibilities document.
- Date upon which this authorization will expire: _____ I understand that I may revoke this release by notifying VR staff at any time in writing and that it will automatically expire within one (1) year of the signature date listed below.

I certify that I agree to the uses and disclosures listed above and that I will receive a copy of this authorization.

_____
Signature of Individual Date

_____
Signature Parent, Guardian, or Authorized Representative Date

_____
Print Name Relationship

NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING VR RECORDS

This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (34-CFR Part 361) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.