Arkansas Division of
Workforce Services
Arkansas Rehabilitation Services

Senior Referral Packet for

Post-Graduation Services

2024-2025

PLEASE RETURN THE COMPLETED FORM TO:

Andrew LeVoir, MS, CRC, CVE
3715 N Business Dr., Suite 104
Fayetteville, AR 72703
Phone: (479) 582-1286
Fax: (479) 582-1762
andrew.levoir@arkansas.gov

Please use the checklist below to ensure that your student's ARS Senior packet is complete ***before*** sending/giving this to the ARS counselor. This packet is ***only*** for students graduating this school year who would like to apply for general vocational rehabilitation services to be in place once they have graduated. This is ***not*** for students applying for pre-employment services. Every item below must be completed/signed and included with the packet for it to be considered complete. Incomplete packets ***will not*** be accepted, and the student may not meet with the counselor assigned to their school until the packet is returned complete. If you have questions about the packet, please contact your appointed ARS counselor.

What you need to refer a student to your local ARS to apply for general vocational rehabilitation services:

☐ **ARS Data forms** (please make sure to complete **all** sections on this form; there are 3 pages; if it is not complete this may delay the process)

☐ **Copy of student's Photo ID (state ID, passport, or school ID for short term)**

☐ **Copy of student's Social Security Card**

☐ **Signed ARS Informed Consent and Release of Information** (Signed by parent, if student is over 18 then student will sign).

☐ **Documentation of Household Income** This would include most recent family tax return or SSI award letter if applicable.

If you are interested in services but do not/did not turn in the documents before the deadline of December 13, 2024, you may still apply for services at your local Arkansas Rehabilitation Services office.

Dear Student, Parent, or Guardian:

Greetings! My name is **Andrew LeVoir, M.S., CRC, CVE** and I am a Vocational Rehabilitation Counselor with Arkansas Rehabilitation Services (ARS). ARS offers multiple services for students with various disabilities including vocational counseling and guidance, job placement services, potential funding for educational and training expenses, as well as other services geared towards helping students achieve gainful employment. I met with you or your student during orientation at your school to share information about our state agency and the potential services you might be eligible for.

If you are interested in pursuing these services then we will need the following documents, including completing/ signing the three forms that have been attached to this letter:

1. Clear copy of Photo ID (State ID, Driver's License, Passport, Student ID)

2. Clear Copy of Social Security Card

3. Copy of Proof of income (This can be the most recent parent/guardian's tax returns or if the students receive SSI for his/her disability then we will just need a copy of the SSI awards letter)

4. Signed Informed Consent- **ATTACHED** (If student is under 18 or parents have legal guardianship then parent must sign.)

5. Signed Release of Information- **ATTACHED**- (This form is so we can get records from your student's physician, mental health counselor, or other provider in order for us to determine his/her eligibility. Again, if your student is under 18 or parents have legal guardianship then the parent must sign.)

6. Completed Data Sheet- **ATTACHED**- ("Personal Information" box should be student's info; parents/guardians should list their information under "additional contact information".)

I will meet one on one with your student at their school to begin the application process to determine his/her eligibility for services.

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Andrew LeVoir, MS, CRC, CVE
Fayetteville Office
3715 N. Business Dr. Suite 104
Fayetteville, AR 72703

OR

Harrison Office
818 Highway 62/65/412N
Harrison, AR 72601
870-741-7153

If you have any questions, please contact me at 479-582-1286 or andrew.levoir@arkansas.gov

High School Attending:__________________ **School Work Program:** __________________

DATASHEET

DEMOGRAPHIC INFORMATION

Can we text you? ☐ **YES** ☐ **NO** **Who is your cell phone provider?**______________________
(Example: Verizon; Tmobile)

PHONE (479) 582-1286 AND FAX (479) 528-1762

Please complete as much of this form as you can. This information will assist your Transition Vocational Rehabilitation Counselor in determining your eligibility and vocational planning. Your information will be kept confidential and only used as necessary for you rehabilitation.

PERSONAL INFORMATION

Last Name		First Name		Middle Initial
Date of Birth		Social Security Number		
Street/Mailing Address	City	County	State	Zip Code
Telephone Number (with area code)	Cell		Home	
Personal Email Address; Parent/Guardian Email as well, if under 18				
Gender/Pronouns	Age	**Preferred Method of Contact:** ☐ Phone ☐ Email		

TRANSPORTATION INFORMATION:

What is your preferred language? Please list: _______________
Do you have a valid driver's license? Yes _____ No______
Do you own a vehicle? Yes________ No_________
Do you have access to a vehicle? Yes_________ No ___________
Can someone give you a ride? Yes ______ No_____ Who? _____
Do you use public transit? Yes_____ No_____

HOUSEHOLD INCOME FOR ALL SOURCES AND/OR BENFITS: $____________________________

SSI for Aged?
☐ Yes
☐ No
Amount? ________

SSI for Disabled?
☐ Yes
☐ No
Amount? ________

SSDI?
☐ Yes
☐ No
Amount? ________

HOUSEHOLD MEMBERS: Who lives in the home with you?

NAME	RELATIONSHIP	AGE	EMPLOYMENT

If more room is needed to add family members, please use back of sheet.

CONTACT INFORMATION (REQUIRED)

If we are unable to reach you, who should we contact? **(May use household members as contacts)**

NAME	RELATIONSHIP	ADDRESS	TELEPHONE NUMBER

What do you plan to do when you graduate high school? (e.g. college, vocational school, work)

____

____

____

What is your vocational (job) goal? (If you have multiple interests, please list them)?

____

What services are you seeking? *Select all that apply.*

- ☐ Tuition/Training Assistance
- ☐ Accommodation
- ☐ Job Search – Preparing for/and finding a job
- ☐ Maintaining a job
- ☐ Other ________________________________
  ____

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Equal opportunity employer/ program. Auxiliary aids and services are available upon request to individuals with disabilities.

STUDENT HEALTH SURVEY:

Family Doctor: ________________________________

Clinic Name:________________________________

Family Doctor: ________________________________

Clinic Name: ______________________________

PLEASE CHECK BELOW ANY OF THE FOLLOWING CONDITIONS OR DISEASES WHICH NOW CAUSE YOU SOME LIMITATION OR DIFFICULTY:

____ Deafness
____ Severe Hearing Loss
____ Speech Problem, severe
____ Learning Impairment
____ ADHD
____ Diabetes

____ Asthma, severe
____ Autism
____ Mental/Emotional Problem
____ Epilepsy
____ Scoliosis
____ Other

Please list if checked other:______________________

How does your disability effect daily living activities? ______________________________________

____

EDUCATIONAL HISTORY

Are you in a school to work program? Yes______No ____

Are you receiving credits from a vocational program such as NTI or NWACC? Yes______No ____

EMPLOYMENT HISTORY **Have you ever been employed?** ☐ **YES** ☐ **NO**

List most recent job below.

Company:	**Job Title:**	**Start Date:**	**Starting Salary:**
Address:	**City, State, and Zip Code:**	**End Date:**	**Final Salary:**
Reason for Leaving (be specific)		**List Job Duties and Skills Used:**	

ETHNICITY

	White/European American		Black/African American
	American Indian/Alaskan Native		Asian
	Native Hawaii/Other Island		Hispanic/Latin

Arkansas Rehabilitation Services
Informed Consent

Client Name ______________________________ ____________________
(Last) (First) (MI) Social Security Number

Authorization is hereby granted for referral of the above named individual to the Arkansas Rehabilitation Services. As parent/guardian I understand that in order to determine eligibility and services required to achieve a vocational goal, a comprehensive evaluation may be required. My signature authorizes the Arkansas Rehabilitation Services to conduct such an evaluation including medical, mental health, psychological, and/or vocational assessments.

Authorization is also granted to Arkansas Rehabilitation Services
(school, agency, clinic)

to release information in the record of the above-named individual to the Arkansas Rehabilitation Services

(Counselor) Counselor, M.S., CRC

(Address) 3715 N Business Dr., Suite 104, AR 72601

Type of information to be disclosed:

- ☒ Medical
- ☒ Psychological
- ☒ Vocational
- ☐ Other (specify) ____________________

Purpose for such disclosure:

- ☒ Establish eligibility
- ☒ Develop VR plan
- ☒ Determine treatment need/type
- ☐ Other (specify) ____________________

I understand the purpose(s) for which my consent is being requested. I understand that giving consent for the above stated purpose(s) is voluntary on my part and may be revoked at any time.

______________________________ ____________________
Parent/Guardian Signature Date

ARKANSAS REHABILITATION SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

Name__________________________Birth Date:____________________Social Security Number: ____________________

1. I hereby authorize use or disclosure of my protected health/vocational information as described below.
2. The following individual or institution, is authorized to make the disclosure:
   ____________________________________ Address: ____
   ____________________________________ ____
3. This information may be disclosed to, and used by, the following individual or institution:
   Counselor, M.S., CRC Address: 3715 N Business Dr. Suite 104
   Arkansas Rehab Services Fayetteville, AR 72703

   For the purpose of ☐ Establishing eligibility for vocational rehabilitation services
   ☐ Developing a vocational program for individual
   ☐ Determining need for, or type of, treatment
   ☐ Other (specify): _____________________________________
4. The specific type of information to be used or disclosed is as follows:

   ☐ History
   ☐ Discharge Summary
   ☐ Office Notes
   ☐ Laboratory Results
   ☐ Consultation Reports regarding______
   ☐ Vocational Records
   ☐ Medication List
   ☐ List of Allergies
   ☐ Immunization Record
   ☐ X-Ray & Imaging Reports
   ☐ Psychoeducational Evaluation & IEP
   ☐ Record of VR services created by ARS and maintained in ECF
   ☐ Other: (specify): _____________________________________

5. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
6. I understand I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the entity that was authorized to release information. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this Authorization expires 12 months following the date of my signature.
7. I understand that authorizing disclosure of my health record is voluntary. I understand any disclosure of my health record carries with it the potential for re-disclosure, which may not be protected by federal confidentiality rules such as the Health Insurance Portability and Accountability Act (HIPPA).
8. To the extent I am authorizing disclosure of the record of VR services created by ARS, this authority is granted under 34 C.F.R. § 361.38(c) (“Release to applicants and recipients of services”), and Arkansas Rehabilitation Services Policy XI-2 (“Release and Confidentiality of Information”).
9. Health information may be faxed: Yes ☐______No ☐_____(initial appropriate space)
10. An electronic copy of this Authorization will be as valid as the original.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

____ _____________________________
Signature of Individual/Representative Date

____ _____________________________
Relationship to Individual, if signed by Representative Signature of Witness