

REFERRAL FORM

You may fill out this form electronically and email it to azrsa@azdes.gov or you may print this form and take it to the RSA office closest to you. To locate the office closest to you, call 1-800-563-1221 or visit the web at www.azdes.gov/rsa and click on Contact Information.

To speak with someone regarding general information about RSA programs or to receive assistance completing a referral for services, please call Toll-Free 1-800-563-1221. By submitting this form I understand I understand that my information will be entered into the RSA client system and I will be contacted by a representative of RSA.

INDIVIDUAL BEING REFERRED

Title: _____ Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (No., Street) _____

City _____ State _____ ZIP Code _____

Residential Address (No., Street) _____

City _____ State _____ ZIP Code _____

Home Phone Number _____ Cell Phone Number _____

Alternate Contact Number _____ Email _____

Video Phone Number _____ VRS IP: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

PARENT/LEGAL GUARDIAN (IF APPLICABLE)

Title _____

First Name _____ Last Name _____

Mailing Address (if different from above) _____

City _____ State _____ ZIP Code _____

Phone Number (if different from above) _____

| Race / Ethnicity | Travel Information | What accommodations do you need for your first appointment? |
|---|--------------------------|---|
| White | Alone | Interpreter Services |
| Black or African American | With a Sighted Guide | ASL |
| Asian | With a Cane | Transliteration |
| Hispanic or Latino | With a Dog Guide | CART |
| Native Hawaiian or Pacific Islander | At Night | Large Print documents |
| American Indian or Alaska Native If checked: Tribal Affiliation: | During the Day | Braille documents |
| | On Public Transportation | Transportation assistance |
| | With a Wheelchair | Other- please list: |
| | With Assistive Devices | |
| | Other: | |

PRIMARY LANGUAGE

Primary Language: _____

Other Languages or Modes of Communication: _____

NAME OF REFERRAL SOURCE

How did you hear about us? _____

Self-Referred

Do you have a DDD case worker? Yes No

If yes, what is the name of your case worker? _____

Do you receive services from a Behavioral Health Clinic? Yes No

If yes, what is the name of your case manager? _____

If yes, what is the name of your clinic? _____

WHAT IS YOUR DISABILITY(IES) PLEASE CHECK ALL THAT APPLY.

- | | | | |
|-------------------|--------------------------------|-------------------------|---------------------|
| Behavioral Health | Blind or Visually Impaired | Deaf or Hard of Hearing | Developmental Delay |
| Cognitive Delay | Other: (please describe) _____ | | |

Do you want to work? Yes No

If yes, please describe your job goal below.

Are you a family member or close associate of an RSA program employee? Yes No

Optional: Please disclose the name of the family member or close associate. _____

Date Submitted: _____