Arkansas Division of
Workforce Services
Arkansas Rehabilitation Services

Senior Referral Packet for

Post-Graduation Services

2025-2026

PLEASE RETURN THE COMPLETED FORM TO:

Teshia Smith
3715 N Business Dr., Suite 104
Fayetteville, AR 72703
Phone: (479) 582-1286
Fax: (479) 582-1762
Lateshia.Smith@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 12, 2026, you may still apply for services at your local Arkansas Rehabilitation Services office.

Dear Student, Parent, or Guardian:

Greetings! My name is **Teshia Smith, M.S., CRC,** 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.

Teshia Smith, CRC
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 Lateshia.Smith@arkansas.gov

High School Attending:_____ **School Work Program:**_____

DATA SHEET

DEMOGRAPHIC INFORMATION

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

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 your rehabilitation.

PERSONAL INFORMATION

Last Name	First Name			Middle Initial
Date of Birth		Social Security Number		
Street/Mailing Address	City	County	State	Zip Code
Can I text you, If needed? Y N Cell Phone Provider:	Cell		Home	
Personal Email Address; Parent/Guardian Email as well, if under 18				
Gender	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_____

Learner's Permit? Yes _____ No_____

HOUSEHOLD INCOME FOR ALL SOURCES AND/OR BENEFITS: $_____

SSI for Aged?	**SSI for Disabled?**	**SSDI?**
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
Amount? _____	Amount? _____	Amount? _____

ETHNICITY

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

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 _____
  _____

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

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:**	

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)?

_____

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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 Condition (ex. Anxiety/Depression)
____ Epilepsy
____ Scoliosis
____ Other

Please list if checked other:_____

How does your disability effect daily living activities? _____

_____

_____

_____

_____

Any other information you believe is important for us to know? _____

_____

_____

_____

_____

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) Teshia Smith, 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:
   Teshia Smith, 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 ☐ Medication List
   ☐ Discharge Summary ☐ List of Allergies
   ☐ Office Notes ☐ Immunization Record
   ☐ Laboratory Results ☐ X-Ray & Imaging Reports
   ☐ Consultation Reports regarding_____ ☐ Psychoeducational Evaluation & IEP
   ☐ Vocational Records ☐ 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