

GENERAL INFORMATION

This Excel file consists of 1 worksheet. The worksheet is labeled as to its function.

If you are unable to see the tab for the worksheet across the bottom of the screen, click on the maximize button (the center button) located in the upper right hand corner of the worksheet. The worksheet is protected to prevent the changing of formulas and formatting features built into the spreadsheets.

You may submit completed forms in an electronic format or printed format. You must ensure that consumer information is protected as required by State and Federal law.

FOR ELECTRONIC FORMATS ONLY: If you submit this form to the regional center as an email attachment or on a CD ROM use the following naming standard: Each file must start with the designation of "F" followed by the provider's three digit numerical designation and the month and year. See chart for month designations. For example: F372-JA04 is Form DS 1968 for provider ID# 372 for January 2004.

FOR ELECTRONIC FORMATS ONLY: This form contains information protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). **The file must be password protected** to ensure the safety of the consumer's information. Coordinate with the regional center regarding protecting the consumer information contained in this form.

Form usage: This form is to be used by regional centers when referring consumers to the Department of Rehabilitation for Vocational Rehabilitation services. This form may also be used when making a referral directly to a Work Activity Program for habilitation services.

Estimated Start Date: Enter the date the consumer is estimated to start Vocational Rehabilitation services or a Work Activity Program. Enter the date as dd/mm/yyyy.

PROVIDER INSTRUCTIONS:**Consumer Information**

Social Security Number: Enter the consumer's nine digit SSN#. **If the SSN # entered is less than or more than 9 digits the field will remain red.**

UCI NUMBER: Enter the consumer's seven digit UCI #. **If the UCI # entered is less than or more than 7 digits the field will remain red.**

Last Name: Enter the consumer's last name.

First Name: Enter the consumer's first name.

Address/City/ZIP: Enter the consumer's address, city, and ZIP code.

Phone: Enter telephone number where consumer can be contacted. Enter telephone number as XXX XXX-XXXX.

Conservator's/Parent Last Name: Enter the Parent, Conservator or designated representative's last name.

First Name: Enter the Parent/Conservator/designated representative's first name.

Mailing Address/City/ZIP: Enter the Parent/Conservator's address, city, and ZIP code.

Phone: Enter telephone number where Parent/Conservator can be contacted. Enter telephone number as XXX XXX-XXXX.

Current Program: Enter the name of the consumer's current program.

Prior Program: Enter the prior program consumer was utilizing.

Consumer Referral Choice

Enter an "x" in the box that indicates whether the consumer was referred to Vocational Rehabilitation or Habilitation Services.

Preferred Provider Name: Enter the consumer's preferred provider's name. Leave blank if the consumer has no choice of provider.

Enter an "x" in the box that indicates whether the consumer will be entered into a WAP (Work Activity Program), Vocational Rehabilitation (VR)-WAP, SEP-IP (Individual Placement) or SEP-GP (Group Placement) program, or has no preference at this time.

Enter an "x" in the box that indicates required reports are attached. Attach required documents to the referral form (CDER [Client Development Evaluation Report] or an IPP [Individual Program Plan]). This form cannot be forwarded electronically based on the requirement to attach a copy of the report. **Note: If required documents do not accompany the referral, the consumer's services may be delayed.**

Enter an "x" in the box that indicates which recent reports, if any: MED (medical), PSY (psychological) or SOC (social history) are attached.

Enter an "x" in the box that indicates required reports were sent to vendor. i.e., (CDER [Client Development Evaluation Report] or an IPP [Individual Program Plan]).

Enter an "x" in the box that indicates which recent reports if any, were sent to vendor, if the consumer selected a service provider (vendor) MED (medical), PSY (psychological) or SOC (social history).

Certification Box - Read paragraph certifying that the consumer requires vocational rehabilitation prior to signing the certification box.

Top Box

RC Name: Enter the abbreviation for the regional center (see attached list) that is authorizing extended services for the consumer.

RC Code: Enter the numerical code for the regional center (see attached list) that is authorizing extended services for the consumer.

RC Representative (Print): Enter the regional center contact's name.

RC Representative (Signature): Regional center representative who is authorizing extended service signs the certification box.

Date: Enter date RC Representative signed the certification box. Enter date as mm/dd/yyyy.

Phone Number: Enter RC Representative's telephone number.

FAX Number: Enter RC Representative's facsimile number. Enter facsimile number as XXX XXX-XXXX.

Email: Enter RC Representative's electronic mail address.

Bottom Box - Read the paragraph stating consumer/conservator/designated representative's understanding that the information on this form will be shared with the Department of Rehabilitation.

Consumer's Signature: Have the consumer/designated representative sign here. This form cannot be forwarded electronically.

Conservator's Signature: Have the consumer's conservator sign here, if applicable. This form cannot be forwarded electronically.

Date: Enter date consumer and/or conservator signed the referral. Enter date as mm/dd/yyyy.

Witness Name: If necessary, enter the witness' name.

Witness' Signature: If necessary, have the witness sign the certification box. This form cannot be forwarded electronically.

NOTICE

Read the notice and use the information to safeguard the consumer's information in accordance with the Health Insurance Portability and Accountability Act (45 C.F.R. Parts 160, 162 and 164).

Regional Center ID #:

Code	ABBRV	RC NAME
360	FDLRC	Frank D. Lanterman Regional Center
361	GGRC	Golden Gate Regional Center
362	SDRC	San Diego Regional Center
363	FNRC	Far Northern Regional Center
364	ACRC	Alta California Regional Center
365	SARC	San Andreas Regional Center
366	TCRC	Tri-Counties Regional Center
367	CVRC	Central Valley Regional Center
368	RCOC	Regional Center of Orange County
369	IRC	Inland Regional Center
370	RCRC	Redwood Coast Regional Center
371	NBRC	North Bay Regional Center
372	KRC	Kern Regional Center
373	ELARC	East Los Angeles Regional Center
374	SCLARC	South Central Los Angeles Regional Center
375	HRC	Harbor Regional Center
376	WRC	Westside Regional Center
377	VMRC	Valley Mountain Regional Center
378	NLACRC	North Los Angeles County Regional Center
379	SGPRC	San Gabriel/Pomona Regional Center
380	RCEB	Regional Center of the East Bay

DOR Vocational Rehabilitation (VR) ID #:

2218	VR	DOR Vocational Rehabilitation
------	----	-------------------------------

Month Designations:

January	JA	April	AP	July	JL	October	OC
February	FE	May	MY	August	AG	November	NO
March	MR	June	JN	September	SE	December	DE