DDARS REFERRAL AND APPLICATION

State Form 10057 (R4 / 4-97)

Civil Rights Act of 1964 (P.L. 88-352)
CONFIDENTIAL per 34 CFR 361.49

DIVISION OF DISABILITY, AGING AND REHABILITATIVE SREVICES
Bureau of Developmental Disabilities Services
Vocational Rehabilitation Services

*Your Social Security number is being requested by this state agency Per IC 4-1-8-1. Disclosure is mandatory and this form cannot be completed without it.

PART 1 – REFERRAL INFORMATION

Name (last, first, middle, maiden)			Date of referral (mo., day, yr.)
Address (street and number, city, state)		County	ZIP code
*Social Security number	Date of birth (mo., day, yr.)	Sex ☐ Male ☐ Female	Telephone number ( )
Disability / diagnosis			
Referral source	Telephone number ( )	If deaf or non-English speaking, is an interpreter needed ☐ Yes ☐ No	
Does the applicant have a driver's license? ☐ Yes ☐ No		Can the applicant use public transportation? ☐ Yes ☐ No	

PART II – APPLICATION/DESCRIPTION

Describe the disability and how it affects the applicant's daily living skills and specific work tasks. How may the services of these agencies assist in accomplishing the goals of the individual and how it will impact on the family.

Name of Doctors / Hospitals Familiar With Applicant Disability / Diagnosis	**Address of Doctors / Hospitals**	**Date and Type of Last Exam**

Describe any medical attention the applicant is now receiving / has received (include medicines, therapies, and counseling)

Name one (1) person who will know the applicant's address in the event of a move.

Name and Relationship	Address (street and number, city, state)	Telephone Number
		( )

List schools the applicant has attended beginning with the most recent (High School, Trade, Business, etc.)

Name of School	City and State	Type of Training Degree / Certificate	Highest Grade Completed and Year

List jobs the applicant has had beginning with the most recent. (*attach additional sheet if necessary)*

Name of Employer, City and State	Job Title	Wages	Reason for Leaving	Employent From	Employent To
1.					
2.					
3.					
4.					

List work tasks on the jobs identified above.

1.

2.

3.

4.

List rehabilitation programs or other agencies at which the applicant has previously received services beginning with the most recent.

Facility or Agency's Name and Address (street and number, city)	Date	Kinds of Services

I have been informed that al information obtained is confidential. I hereby give consent for the release of information related to my physical, mental and social condition by the Division of Disability, Aging and Rehabilitative Services. Such information is to be used only by persons or agencies authorized to help in my habilitation / rehabilitation program. This consent will remain valid as long as I am seeking or receiving services from the agencies. I have received written information concerning my right to appeal certain decisions made by these agencies and their contractors or vendors and the procedures to be followed in making such an appeal. I hereby apply for services from (*check one or both)* ☐ Vocational Rehabilitation Services ☐ Bureau of Developmental Disabilities Services.

Signature of applicant / parent / guardian / advocate	Date signed (mo., day, yr.)

I acknowledge the receipt of Notification of Parent / Client Rights and the opportunity to have these rights explained to me. (*for BDDS applicants)*

Signature of parent / guardian or advocate	Date signed (mo., day, yr.)