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| **RAISING A STANDARD, INC.** | | |
| **Vocational Rehabilitation Office Location**: | R.A.S. Vendor Id#: | ***Office Use Only***  **Client No**.  **Entered on database ☐**  **By:**  **Date:** |
| **Counselor Name**: | |  |
| **Tel:** | **Email** | |
| **Date:** |  | |
| Client Details | | |
| **Title** Mrs☐ Ms☐Miss☐  Mr☐ Dr☐ Other☐ | **Name:** | |
| **Address:** | | **CLIENT ID**: |
| **Date of Birth:** | | |
| ☐ ☐ | | |
| **Main Telephone**: | **Mobile**: | **Emergency No**: |
| **Email:** | | |
| **Main Disability/Condition**: | **Other Disability/Conditions**: | **Emergency contact name:**: |
| *SERVICES:*  *☐ Supported Employment ☐Vocational Evaluation (Comprehensive) ☐ Job Readiness Training ☐ Work Evaluation*  *☐ Job Coaching ☐ Work Adjustment Training (Community) ☐ Personal/Social Training* | | |
| **Medication**  **Please list** | | |
| **Length of service?** | | |
| **Does the person know about this referral? Yes**☐ **No**☐  **Counselor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **R.A.S. Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **R.A.S. Office Use;**  **Referral Accepted Yes**☐ **No**☐ Date: | | |

Email: [raiseastandardinc@gmail.com](mailto:raiseastandardinc@gmail.com)