

Kentucky Office of Vocational Rehabilitation

Referral Form Instructions

Case Information

Counselor	Enter the name of the counselor
Caseload	Enter the caseload number (6 digits)
Case Number	Enter the case number (6 digits)
Referral Date	Enter the date that the referral was taken

Consumer Information

First Name	Enter the first name of the referral
MI (Middle Initial)	Enter the middle initial of the referral
Last Name	Enter the last name of the referral
Preferred Name	Enter the name that the referral prefers to be called

Preferred Pronouns

Enter the pronouns that the referral prefers

Secondary Student ID

Enter the secondary student ID (if applicable)

Date of Birth

Enter the referral's date of birth (mm/dd/yyyy)

SSN (Social Security Number)

Enter the social security number for the referral (9 digits); check box for SSN not available or not disclosed if the consumer can't/doesn't share their SSN

Legally eligible to work in the U.S.

Select yes or no on whether the referral is legally eligible to work in the U.S.

Primary Address

Enter the street number and name for the referral

City

Enter the name of the city in which the referral resides

State

Enter the name of the state in which the referral resides

Zip

Enter the zip code (5 digits) in which the referral resides

County

Select the county in which the referral resides

Mailing Address	Enter the street number and name where the referral would like to receive mail (click the box if the mailing address is the same as the primary address)
City	Enter the city in which the referral resides
State	Enter the state in which the referral resides
Zip	Enter the zip code (5 digits) in which the referral resides
County	Select the county in which the referral resides
Phone Number	Enter the referral's phone number
Alt Phone Number	Enter the alternate phone number (if applicable) for the referral
Email Address	Enter the referral's email address (if applicable)
Referral Source	Select the referral source for the referral
Referral Source Comment	Enter any comments for the referral source
Reported Impairment	Select the reported impairment

Reported Cause for Impairment	Select the reported cause for the impairment
Alternate Contact Person Name	Enter the name of the alternate contact person for the referral
Alternate Contact Phone	Enter the phone number of the alternate contact person for the referral
Alternate Contact Email	Enter the email of the alternate contact person for the referral
Parent/Guardian Name	Enter the name of the parent and/or guardian for the referral if applicable
Parent/Guardian Phone	Enter the phone number for the parent and/or guardian for the referral if applicable
Parent Guardian Email	Enter the email for the parent and/or guardian for the referral if applicable
Guardian Type	Select the guardian type for the guardian if applicable

Vision Information

If the referral has a problem with vision, please complete the vision questions. If not, skip to the hearing information.

Has the individual been diagnosed with a vision impairment?

Select yes or no on whether the referral has a vision impairment

If yes, describe the individual's vision impairment.

Enter a specific description of the individual's vision impairment

Would the impairment be corrected with glasses?

Select yes or no on whether the referral's impairment would be corrected with glasses

Does the individual use visual aids, such as magnifiers?

Select yes or no on whether the referral uses visual aids, such as magnifiers

Describe the visual aids used.

Enter a specific description of the visual aids that are used by the referral

How does the individual access print?

Enter a specific explanation of how the referral accesses print

How does the individual maneuver in unfamiliar environments?

Enter a specific explanation of how the referral maneuvers in unfamiliar environments

Does the individual have problems with curbs or steps?

Select yes or no on whether the individual has problems with curbs or steps

Does lighting change the individual's vision?

Select yes or no on whether lighting changes the individual's vision

If yes, how does lighting change the individual's vision?

Enter a specific explanation of how lighting changes the individual's vision.

Does the individual have problems cooking or cleaning due to their vision?

Select yes or no on whether the referral has problems cooking or cleaning due to their vision

If yes, what cooking or cleaning problems are due to the individual's vision?

Enter a specific description of what cooking or cleaning problems are due to the referral's vision

How does the individual read their mail, email, and/or attend virtual meetings?

Enter a specific description of how the referral reads their mail, email, and/or attends virtual meeting

If the individual has been evaluated by an eye doctor, does the individual have 20/50 or worse vision?

Select yes or no on whether the individual has 20/50 or worse vision

Does the individual have visual field loss?

Select yes or no on whether the individual has visual field loss

If yes, how does it affect the individual?

Enter a description of how the visual field loss affects the individual

Hearing Information

If the referral has a problem with hearing, please complete the hearing questions. If not, skip to the retain information.

Does the individual have a hearing impairment?

Select yes or no on whether the referral has a hearing impairment

If yes, please choose the hearing impairment type.

Select the hearing impairment type for the referral

How/when did the individual start experiencing hearing loss?

Enter a description of how and when the referral started experiencing hearing loss

What is the individual's communication preference?

Select the referral's communication preference

If other, please specify.

If the referral has a different communication preference not represented in the previous question, please specify the communication preference that applies in the space provided

Does the individual use interpreters in various settings?

Select yes or no on whether the referral uses interpreters in various settings

Does the individual use the text to speech app? Select yes or no on whether the referral uses the text to speech app

Does the individual use captions on TVs or videos? Select yes or no on whether the referral uses captions on TVs or videos

RETAIN Information

RETAIN Kentucky is a federally-funded research study implemented by the University of Kentucky designed to expand services to help thousands of newly injured and ill employees across the Commonwealth stay in the workforce. The free program is open to individuals 18 and older who have non-occupational illnesses or injuries that prevent them from performing their jobs. Participants will get support to identify their stay-at-work and return-to-work goals and take steps to achieve those goals.

Please answer the RETAIN questions to see whether the referral is eligible for the RETAIN program.

Does the individual live in Kentucky? Select yes or no on whether the referral lives in Kentucky (The answer must be yes if the referral is to be eligible for the program)

Is the individual working or has worked in the last 12 months? Select yes or no on whether the referral is working or has worked in the last 12 months (The answer must be yes if the referral is to be eligible for the program)

Does the individual have an injury or illness that did not happen at work, which prevents the individual from working or could potentially prevent the individual from working?

Select yes or no on whether the referral has an injury or illness that did not happen at work, which prevents the individual from working or could potentially prevent the individual from working

(The answer must be yes if the referral is to be eligible for the program)

Does the individual currently receive Social Security disability benefits (SSI/SSDI) OR have they applied for Social Security disability benefits in the last three years?

Select yes or no on whether the referral currently receives Social Security disability benefits (SSI/SSDI) OR have they applied for Social Security disability benefits in the last three years

(The answer must be No if the referral is to be eligible for the program)

If the referral is eligible based on the answers to the questions, the referral should be connected to RETAIN. Please use the contact information for RETAIN on the referral form. Once the referral is referred to RETAIN, the form is placed until the comparable benefits tab in CMS.

Next Steps/Notes

Application Meeting Date

Enter the date of the application meeting

Meeting Type Preference

Select the meeting type preference of the referral

Consumer agrees to communicate or sign documents with the counselor using DocuSign and/or SARA.

Select DocuSign and/or SARA

SARA Summary:

SARA is our main communications system that let us stay in contact with you and you with us. It is basically a virtual assistant that keeps in contact with you at regular intervals to see how you are progressing and helps us service you better. SARA communicates with you using email and text messaging. If you receive a text message from 857-60, it's from SARA. SARA also sends you an email if we have your email address. You can use either to respond.

Notes

Please put any notes about the referral in this section, especially items not covered on the referral form