OVR

(rev. 01/2024)

Kentucky Office of Vocational Rehabilitation
Independent Living (IL) Services Referral

Kentucky Career Center
Vocational Rehabilitation

1. Consumer Information

Name	Case Number	Date of Birth *(MM/DD/YYYY)*

Address

City	State	Zip Code

Cell Phone	Home Phone	Email Address

Emergency Contact Name	Emergency Contact Phone Number

2. Other Service Provider(s)

Please provide contact information for other service providers who should be involved in the services requested (i.e., job placement providers, employer, etc.)

1. Name	
Title	**Organization**
Phone Number	**Email Address**
2. Name	
Title	**Organization**
Phone Number	**Email Address**

3. Independent Living Services

Does the Consumer have an open VR case?
Has this individual received previous Independent Living (IL) Services? *(If yes, please provide estimated dates of services and a description of IL services received)*
What are the current Independent Living needs of this individual?

4. Disability Information

Does the consumer have a secondary disability which impacts their ability to participate in IL services? *(If yes, please explain)*
Does the Consumer have a Hearing Impairment? *(If yes, please explain Impairment and devices/accommodations needed, i.e., hearing aid(s), amplification, interpreter, etc.)*

Does the Consumer have a Mental Health diagnosis? *(If yes, please indicate where to locate supporting documentation in CMS, including folder and document title.)*
Has the Consumer received counseling for diagnosis or adjustment? *(If yes, please indicate where to locate supporting documentation in CMS, including folder and document title.)*
Do you have any safety concerns regarding the Consumer's past or current behavior? *(If yes, please describe.)*

5. Medical Information

Is the consumer diabetic?	**If yes, are they insulin dependent?**
Does the consumer take any medications? *(If yes, please send complete medication list with application)*	
Please explain any other current or past medical conditions that IL staff need to be aware of.	

6. Educational and Vocational Information

Is this individual currently a secondary or post-secondary student? *(If yes, please provide details, including anticipated start/completion dates, school, and field of study, if applicable.)*

Is this individual currently working or pursing employment? *(If yes, please provide employment and/or job search related details.)*

7. Previous Assessments

Has the Consumer had any of the following assessments previously completed?

(Select all that apply. Reports should be available in CMS

- ☐ Assistive Technology
- ☐ Audiology
- ☐ Bioptic
- ☐ CDPVTC Services
- ☐ Independent Living
- ☐ IPE/504 Plan
- ☐ Orientation & Mobility
- ☐ McDowell Center
- ☐ Neuropsychological
- ☐ Post Secondary
- ☐ Vision Acuity
- ☐ Vision – Visual Fields
- ☐ Other

If other, please specify

8. Assistive Technology Services

Has a referral been made for Assistive Technology Services? *(If yes, please specify what services have been requested or received.)*