OVR 1

(Rev. 1/15/2026)

Kentucky Office of Vocational Rehabilitation
Referral for OVR Services

Kentucky Career Center
Vocational Rehabilitation

*Denotes Required Fields

INDIVIDUAL INFORMATION

*Referral Date *(mm/dd/yyyy)*	*SSN *(9 digits) – Enter N/A if not disclosed)*

*First Name	MI	*Last Name

*Date of Birth *(mm/dd/yyyy)*	Preferred Name

Parent/Guardian Name *(if applicable)*	Guardian Type

Parent/Guardian Phone	Phone Type	Current Student?

Student ID	Current School *(if applicable)*

*Source of Referral

Referral Source Comment *(if self-referred, include how you hear about the Office of Vocational Rehabilitation?)*

Unhoused?	*Address – Line 1 *(Street Address)*	Address – Line 2 *(Apartment, Suite, Unit, etc.)*
☐		

*City	*State	*Zip Code	*County

Email Address	*Phone 1 *(Primary)*	Phone Type

Secondary Contact Name	Secondary Contact Phone	Secondary Contact Email

*Reported Impairment

*Reported Cause

Do you require any accommodations? *(i.e., physical, interpreters, braille documents, etc.)*
***Meeting Type Preference**

VISION

***Do you have visual impairment?**	**Is your vision correctable with glasses?**
If your vision is not correctable with glasses, please share the type of visual diagnosis	

HEARING

***Do you have a hearing impairment?**	**If yes, choose the hearing impairment type**
What is your communication preference?	**If other, please specify**
Do you use interpreters in various settings?	

FOR OFFICE USE ONLY

***Staff member taking the referral**	***Case Number** *(6 digits)*	**Application Meeting Date** *(mm/dd/yyyy)*

***Counselor First Name**	**MI**	***Counselor Last Name**	***Caseload** *(6 digits)*
Comments *(i.e., what services is the individual looking for?*			

Submit

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