Kentucky Career Center
Vocational Rehabilitation

Charles W. McDowell Rehabilitation Center

Request for Services Checklist

- [ ] Completed Request for Services Form
- [ ] Criminal Background Check
- [ ] CAN Check (Only for Consumers with IPE goal in Human Service Field)
- [ ] Previous Psychological Reports, if applicable
- [ ] Most Recent Vision Report
- [ ] Any Previous Training or Rehabilitation Reports
- [ ] Social Security Disability Information, if applicable
- [ ] Treatment Plans for Addictions or Negative Behaviors, if applicable
- [ ] Medical History Questionnaire (Day and Dorm Students Only)
- [ ] Medical Documentation/Reports (Day and Dorm Students Only)
- [ ] Documentation of Dietary Restrictions (Day and Dorm Students Only)
- [ ] Medications List (Day and Dorm Students Only)
- [ ] Medical Releases, if applicable (Day and Dorm Students Only)

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Request for Services

To ensure this form is accessible for all staff, please fill out electronically and email to Hope LaVertu at hope.lavertu@ky.gov

Delivery Method of Training *(*If Dorm is selected, Consumer must have a residence to go to when the Center is closed for occasional holidays and staff in-service.)*

Requested Program(s) *(select all that apply)*

- ☐ Blindness Skills Training
- ☐ Bioptic Driving Only
- ☐ Psychological Evaluation Only
- ☐ Vending Program Only
- ☐ Vocational Assessment Only *(if training recommended consumer will receive introduction to all core areas.)*

Funding Source

Consumer Information

Consumer Name *(First, MI, Last)*

Counselor

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

Gender

Application Date *(mm/dd/yyyy)*

Address *(Street Name and Number)*

City

State

Zip

Cell Phone

Home Phone

Email Address

☐ *(same as cell phone)*

Emergency Contact Name

Emergency Contact Phone

☐ Does Consumer have legal guardian? *(If yes, please list name below and send legal documentation.)*

☐ Does Consumer have payee? *(If yes, please list name below and send legal documentation.)*

☐ Does Consumer use a guide dog or other service animal? *(If yes, please send proof of current vaccinations.)*

Highest Grade Completed

Does Consumer have an IPE? *(if yes, please send with application)*

Work History *(if applicable, include Employer Name and Dates Employed)*

Preferred Matter *(please mark all that apply)*

☐ Standard-sized print

☐ Large print

Minumum font size

☐ Contracted Braille

☐ Uncontracted Braille

☐ Electronic Material

☐ Closed Circuit Television (CCTV)

Disability and Medical Information

Cause of Vision Impairment

Date of onset

Visual Acuity

OD OS OU

Visual Field

OD OS OU

☐ 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, send any supporting documentation)*

☐ Has the Consumer received counseling for diagnosis or adjustment? *(If yes, send any supporting documentation)*

☐ Has the Consumer worked with a Rehab Tech? *(If yes, send any supporting documentation)*

Consumer's previous experience(s) in rehabilitation services, including the McDowell Rehabilitation Center (please include approximate dates)

Additional Information

List specific questions that you would like answered about this Consumer
(Vocational goals/targets, training goals/targets, AT needs, O&M needs, etc.)

What is your perception of this Consumer's adjustment to their Visual Disability? Do you have any concerns regarding this Consumer's behavior? *(i.e., current, or past substance abuse)*

What natural supports and/or community resources does Consumer have currently, and what is available to them?

Requested Programs

Vocational Consumer

☐ ** Newly referred Vocational Consumers will receive an introduction evaluation to all *CORE* training areas, including: Assistive Technology; Braille; Financial Management; Health Management; Home Management; Orientation and Mobility; Personal Adjustment Counseling and Progressive Employment.

☐ In addition, Vocational Consumers can receive the following services by request: *(*If applicable, please indicate any areas of focus, and/or specific training requests in the space(s) provided.)*

Academic Skills Remediation

☐

Vocational Evaluation

☐

Psychological Evaluation

☐

IL/IOB Consumer

**Newly referred IL/IOB Consumers will receive an introduction evaluation to all *CORE* training areas, including: Assistive Technology; Braille; Financial Management; Health Management; Home Management; Orientation and Mobility; and Personal Adjustment Counseling. *(*If applicable, please indicate any areas of focus, and/or specific training requests in the space provided.)*

Medical Information

*Please complete this section for all Day and Dorm Consumers

Is Consumer able to independently perform all Activities of Daily Living (ie, bathing, dressing, toileting)?

☐ Does the Consumer have diet restrictions and/or special dietary needs? *(If yes, please describe below and send medical documentation of prescribed dietary plan.)*

Is Consumer Diabetic? _____

If so, is Consumer Insulin Dependent? _____

Does the Consumer take medications? *(If yes, please send complete medication list with application.)*

_____

Can the Consumer administer their own medications? *(If no, Staff Nurse can train Consumer on medication management plan to help Consumer independently administer and manage medications.)*

_____

☐ Does Consumer have mobility limitations?*(If yes, please explain and list equipment used, i.e., wheelchair, walker, scooter, shower chair)*

Does the Consumer have any allergies (drug, food, other)? *(If yes, do they have epi-pen prescribed?)*

_____

Please describe any allergies as reported by consumer

Please explain any other current or past medical conditions that staff need to be aware of prior to admission