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| **Texas Workforce Solutions logo** | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Referral for Wellness Recovery Action Plan (WRAP) or Supportive Residential Services (SRS)** | | | | |
| **General Instructions** | | | | | |
| Follow the instructions below when completing this form:   * VR staff collects the information and completes **all** sections of this form; * Complete the form electronically answering all questions; * VR counselor must evaluate each customer’s case to determine when remote services are in the best interest of the customer and whether the customer has access to required resources and has the skills necessary for effective use. VR counselor will indicate under WRAP service how the service must be delivered. Some services are not allowed to be conducted remotely.   Below is a description of how services can be conducted:   * In-person (with the staff and customer(s) at the same physical location) * Remotely training (using a computer-based training platform that allows for face-to-face and/or real time interaction, see VR-SFP 3.6.4.1 Remote Service Delivery for requirements) * Combination, in person and remotely training; and * Before faxing, emailing encrypted, or mailing to the provider, review this form to ensure that all sections have been completed. | | | | | |
| **Customer Information** | | | | | |
| Date of the Referral: | | | | | |
| Referral for:  Wellness Recovery Action Plan  VR counselor approves the training to be provided: (check one)  In person  Remotely  Combination, in person and remotely  Supportive Residential Services | | | | | |
| Customer name: | | | | | |
| Case ID: | | | Date of birth: | | |
| Street address (include apartment number, if any): | | | | | |
| City: | | | State: | | ZIP code: |
| Primary contact number:  (   ) | | | Secondary contact number:  (   ) | | |
| Email address: | | | | | |
| Customer disability: | | | | | |
| **Alternate Contact Person Information** | | | | | |
| Alternate contact name: | | | Alternate contact’s relation to Customer: | | |
| Alternate contact primary contact number:  (   ) | | | Alternate contact secondary contact number:  (   ) | | |
| **Additional Information Provided by TWS-VRS at Referral** | | | | | |
| Check all records included with referral. | | | | | |
| IPE copy (or JAR)  Case notes (eligibility, comprehensive assessment) | | Medical and/or psychological reports  Other: | | | |
| **Counselor Contact Information** | | | | | |
| Counselor name: | | | | | |
| VR office: | | | | | |
| Mailing address (include suite number, if any): | | | | | |
| City: | | State: | | ZIP code: | |
| Phone number:  (   ) | | Fax number:  (   ) | | | |
| Email address: | | | | | |
| **Facility Provider** | | | | | |
| Provider name: | | | | | |
| Email address: | | | | | |
| Provider phone number:  (   ) | | Fax number:  (   ) | | | |
| **Additional Comments** | | | | | |
| Additional Comments: | | | | | |