



Texas Workforce Commission  
Vocational Rehabilitation Services  
**Intensive Work Preparation and  
Life Skills Training —Referral**

### General Instructions

Follow the instructions below when completing this form:

- Refer to the Standards for additional details;
- Complete the form electronically answering all questions; and
- Before faxing, emailing encrypted, or mailing to the provider, review this form to ensure that all questions have been answered.

**Note:** The TWS-VRS staff collects the information and completes **all** sections of this form.

### Referral Information

Date of the Referral:

### Customer Identification Information

Customer name:

Street address (include apartment number, if any):

City:	State:	ZIP code:
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Primary contact number: ( )	Secondary contact number: ( )
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Email address:

VRS Case ID:	Date of birth:
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Customer disability:

### Alternate Contact Person Identification Information

Alternate contact name and relationship to customer:

Alternate contact's primary contact number: ( )	Alternate contact's secondary contact number: ( )
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Alternate contact's email address:

### Prerequisite Requirements

Indicate whether the customer meets the following criteria:

Does not have a history of extreme violent or sexual criminal offenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does not currently use drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is able manage his/her daily personal care: bathing/hygiene, dressing and toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Demonstrates the capacity to engage in therapeutic activity 12 hours a day	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is able to attend and participate in classroom instruction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will be able to transfer skills learned to their identified discharge setting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is willing to pro-actively set and reach goals related to work skills and life skills	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a discharge plan identified and available	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has family or caregivers willing to participate customer's discharge plan to foster the skills gain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the customer have a Berkman Assessment Completed	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Additional Information Provided by Vocational Rehabilitation Services at Referral**

Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> IPE copy   | <input type="checkbox"/> Vocational testing                          |
| <input type="checkbox"/> Medical and/or psychological reports                           | <input type="checkbox"/> Work history collected by TWS-VRS           |
| <input type="checkbox"/> Berkman Assessment   | <input type="checkbox"/> Behavior Plans                              |
| <input type="checkbox"/> School Records   | <input type="checkbox"/> Adaptive Technology Evaluations and Reports |
| <input type="checkbox"/> Case notes (for example, eligibility, assessment and planning) |  |
| <input type="checkbox"/> Other:   | <input type="checkbox"/> Other:                                      |

**Reasons for Referral**

Describe the reason for referral:

Identify areas to focus on in the evaluation and skills training:

**Life Skill Area(s) (select all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Advocacy, Communication and Social Skills | <input type="checkbox"/> Advocacy and Legal Issues                  |
| <input type="checkbox"/> Food Management                           | <input type="checkbox"/> Personal Appearance and Hygiene Management |
| <input type="checkbox"/> Money Management and Advocacy             | <input type="checkbox"/> Time Management                            |
| <input type="checkbox"/> Disability and Health Management          | <input type="checkbox"/> Transportation Skills                      |
| <input type="checkbox"/> Personal Safety                           | <input type="checkbox"/> Other:                                     |
| <input type="checkbox"/> Other:                                    | <input type="checkbox"/> Other:                                     |

**Work Readiness Skill Area(s) (select all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Work behavior and attitudes              | <input type="checkbox"/> Work Rules and Expectations                     |
| <input type="checkbox"/> Work Problem Solving and Decision Making | <input type="checkbox"/> Work Ethic                                      |
| <input type="checkbox"/> Work Soft Skills                         | <input type="checkbox"/> Health and Safety at Work                       |
| <input type="checkbox"/> Work Tolerance                           | <input type="checkbox"/> Employee Benefits, Payroll, and Paycheck Basics |
| <input type="checkbox"/> Work Skills Exploration                  | <input type="checkbox"/> Interview Training                              |
| <input type="checkbox"/> Other:                                   | <input type="checkbox"/> Other:  |
| <input type="checkbox"/> Other:                                   | <input type="checkbox"/> Other:  |

## Counselor Contact Information

Counselor name:

Counselor primary TWS-VRS office:

Counselor TWS-VRS office street address (include suite number, if any):

City:

State:

ZIP code:

Counselor's primary contact number:

(    )

Counselor's secondary contact number:

(    )

Email address:

## Provider Chosen by the Customer

Provider name:

Email address:

Provider phone number:

(    )

Provider fax number:

(    )

## Additional Comments

Additional Comments: