Workforce New Jersey
Division of Vocational Rehabilitation Services
Referral Form

60 State Street, 2nd Floor, Hackensack NJ 07601
Phone: (201) 996-8970, Fax: (201) 996-8880, TTY: (201) 487-6348

Vocational Rehabilitation Agencies assist individuals with disabilities to prepare for, obtain and/or keep suitable jobs. The rehabilitation services the agency can provide depend on the availability of State and Federal funds and on the availability of other programs and services. All individuals have the responsibility to: participate financially in their plan to the best of their ability; obtain services only with prior written approval; cooperate by using community services when they can be of help in the rehabilitation program; maintain regular contact with the VR agency counselor; and, go to work when the VR program is completed.

Name: _____ Date: _____

Address: _____ County: _____

City: _____ NJ Zip: _____ Telephone Number: _____
E-Mail Address: _____
Social Security Number _____ Veteran? (Y or N)_____

Disability: _____

Have you ever applied to DVRS before? (Y or N): If yes, when? _____
Where? _____

Do you receive Social Security Benefits? (Y or N)_____ SSD_____ SSI_____
If checked YES, have you received a "TICKET" to work. (Y or N)_____

Do you receive: Welfare Benefits? (Y or N)_____ If yes, please give case number below:
TANF Case Number_____ General Assistance Case Number _____

Birth Date: __/__/__ Sex: __ Number of dependants_____ Marital Status _____
Race: White:____ Black/African:____. Hispanic/Latino:___. Other (Please Specify):_____

Highest grade completed in school? _____

English speaking? (Y or N): Spanish speaking? (Y or N)_____ Other?_____
Deaf ASL: _____ Deaf (oral): _____ Hard of Hearing (sign): _____ Hard of Hearing (oral): _____
Referral Source:

Name: _____ Phone Number: _____

Organization: _____

Address: _____

Reason for referral: _____

COD: #_____ ASSIGN TO/DATE: ___