FRIENDS of Coastal GA LLC
Vocational Rehabilitation Services
Referral for Supported Employment Services

REFERRAL SOURCE INFORMATION

Reason for Referral _____ Date _____

Referral Source Name _____ Referral Source Title_____

Referral Source Contact Information

_____ _____ _____ _____
office cell fax email

Affiliated Agency Name _____

Agency Address _____ _____ _____ _____
street city state zip

Has client been made aware of this referral? ☐ YES ☐ NO
If this is a self-referral, check this box ☐

CLIENT INFORMATION

Client Name _____

DOB _____ Age _____ Race _____ Gender _____

Social Security Number _____ Primary Language Spoken _____

Home Address _____ _____ _____ _____
street city state zip

Home Phone _____ Cell _____ Email _____

County of Residence _____

Emergency Contact Name _____

Home Phone _____ Cell _____ Work _____

Does client have a legal guardian? ☐ Yes ☐ No Guardian aware of referral? ☐ Yes ☐ No ☐ N/A
(If so, attach document verifying guardianship)

Legal Guardian Name _____

Home Phone _____ Cell _____ Email _____

FRIENDS of Coastal GA LLC 528 Golden Grove Lane Richmond Hill, GA 31324
888-508-1012 phone; 888-558-9897 fax info@friendsofcoastalga.com www.friendsofcoastalga.com

CLIENT TRANSPORTATION

Select client's mode of transportation

Has a vehicle ☐ Bus ☐ Taxi/Uber/Lift ☐ Other ☐

If other, please, describe _____

EDUCATION * WORK * TRAINING EXPERIENCE

Highest Education Level Completed	Institution Name	Year Completed	If not completed, why?

Current employment status ☐ Employed ☐ Unemployed ☐ Volunteer

Past Employers	Start Date	End Date	Reason for leaving

Desired Work _____

Describe any work experience _____

_____

List any Certifications/Achievements/Specialized Training _____

_____

List all special accommodations needed _____

_____

Does client have a desire to engage in locating employment? ☐ Yes ☐ No

FINANCIAL INFORMATION * SOURCE OF INCOME

Source of income ☐ SSI ☐ SSD ☐ VA ☐ Retirement ☐ Child Support ☐ No Income

Other benefits _____

If source of income is pending, please give date application was submitted _____

Representative Payee (if applicable) ☐ Yes ☐ No ☐ N/A

Representative Payee Name _____ Phone _____

Power of Attorney (if applicable) ☐ Yes ☐ No ☐ N/A

Power of Attorney Name _____ Phone _____

MENTAL HEALTH INFORMATION

Please attach a recent psychiatric/psychological evaluation or doctor's letter to verify client's diagnosis.

Diagnosis _____	Code _____
Diagnosis _____	Code _____

MENTAL HEALTH INFORMATION CONT'D

List all medical conditions _____

_____

List all medications _____

_____

Any known risk-taking behaviors (recent suicide attempts, illegal drug use, etc.)? ☐ Yes ☐ No

History of violence or aggression? ☐ Yes ☐ No

If yes, provide details _____

LEGAL HISTORY

Does client have a criminal history? ☐ Yes ☐ No If yes, proceed below.

Criminal Charges (within past 5 years)	Arrest Date	Outcome of Arrest	Release Date (if applicable)	Convicted	Time Served (if applicable)
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Probation involved? ☐ Yes ☐ No ☐ N/A If yes, level: ☐ County ☐ State ☐ Federal

Probation Officer Name _____ Phone _____ Email _____

Parole involved? ☐ Yes ☐ No ☐ N/A If yes, level: ☐ County ☐ State ☐ Federal

Parole Officer Name _____ Phone _____ Email _____

AUTHORIZATION FORM

I agree to this referral and authorization. In the event I cannot be reached or if additional information is needed,

I authorize _____ and/or _____ who are listed within this
(vocational rehab staff member) (legal guardian)

referral to be contacted on my behalf for the purpose of coordinating/completing this referral. In addition, I authorize FRIENDS of Coastal GA LLC access to my mental/behavioral health information which was addressed in this application.

_____ _____

Client's Signature Date

_____ _____

Referral Source Signature Date