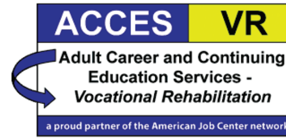


Pre-Employment Transition Services Referral Form for Students with Disabilities

A person with an open case with ACCES-VR is not able to participate in this program.

Student Name: ____
(First) *(Middle)* *(Last)*

Mailing Address: *(No., Street)* ____

City: ____________________ State: ________ Zip Code: __________ Phone Number: ____________

County: ☐ Allegany ☐ Broome ☐ Chemung ☐ Chenango ☐ Delaware ☐ Otsego ☐ Schuyler ☐ Steuben ☐ Tioga ☐ Tompkins

Email Address: ____

School Name: ______________________________________ Grade: ________

School Phone Number: ____________________ Expected Graduation Date: ____________________

If you will need accommodations to participate in services, please describe: ______________________________

____

Pre-Employment Transition Services Requested: (Check all that apply)

___ Job Exploration Counseling

___ Workplace Readiness Training to Develop social skills and independent living

___ Work Based Learning Experience

___ Counseling on opportunities for post-secondary education/training

___ Self-Advocacy Instruction/Self-Awareness

Complete below information for initial request:

Gender: ___M ___F ___Unidentified Date of Birth: ____________ SSN: ____________________

Race/Ethnicity *(check all that apply)*:

___ Asian ___ American Indian/Alaska Native ___ Native Hawaiian/Pacific Islander ___ Black/African American

___ Hispanic/Latino ___ White

By signing this form, I am requesting Pre-Employment Transition Services, from the Arc Allegany-Steuben Pre-ETS Program. This is for the specific purpose of participation in Pre-Employment Transition Services. The confidentiality of personal information requested on this form and with this authorization is protected by 34 CFR 361.38. By signing this form, I am agreeing to the release/obtain of information with Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR) authorization to obtain/release Information (including school records, disability information and status of ACCES-VR process).

Student Name *(Please Print)*: ____

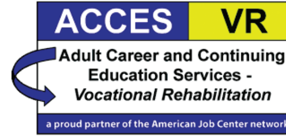
Student Signature: ____ Date: ____________

(If participant is under 18, a parent or legal guardian signature is required. Legal guardianship documents must be provided.)

___ Parent ___ Legal Guardian

Name: ____ Date: ____________
(Printed) *(Signature)*

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability,' genetics and retaliation.



Pre-Employment Transition Services Referral Form for Students with Disabilities

A person with an open case with ACCES-VR is not able to participate in this program.

Student With a Disability Verification

Definition: A 'student with a disability' is defined as an individual with a disability in a secondary , postsecondary, or other recognized education program who is not younger than 14 and up to their 22nd birthday; is eligible for, and receiving special education or related services under Part **B** of IDEA; or who is a student with a disability under section 504. This includes secondary students who are homeschooled, college programs, and students in non-traditional secondary education programs such as special education programs within the juvenile justice system, GED programs, and occupational training programs.

***If this request form is being completed by school personnel, please verify the following:**

Student With a Disability Verification

By signing this form, I verify that the individual identified above meets the definition of a student with a disability. and is

- ☐ A student with a disability for the purposes of section 504; **or**
- ☐ A student with a disability and is receiving transition services under an Individualized Education Plan (IEP)
- ☐ A student with a disability with documentation other than for the purposes of section 504 or an IEP

****Please Note: For classification of ED and OHI please include medical documentation verifying disability.***

School Personnel Name & Date: ____

(Printed) *(Signature)*

Proof of disability is required. One of the following supporting documents must be included with the submitted request form:

- Individualized Education Plan (IEP) or 504 Plan
- Proof of receipt of SSI/SSDI based on individual's own disability (SSI/SSDI award letter)
- Medical or psychological documentation with diagnosis signed by a licensed professional

Please submit this completed form and supporting documentation (if applicable) to:

Marta Cramer
Pre-ETS Manager
One Arc Way, Bath, NY 14810
mlcramer@thearcas.org
607-776-4146 ext. 2213

Christina Lyon
Director of Vocational Education
50 Farnum Street, Wellsville, NY 14895
christina.lyon@thearcas.org
585-593-5700 ext. 227

(For Official Use Only)

Date Referral Received ______________________________

Services will be provided through ______________________________ **due to location.**