# 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

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**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).**

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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: ____________________________________________ (Printed) (Signature) Date: __________

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*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.*
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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
585-593-3005 ext. 227

Date Referral Received __________________________

Services will be provided through __________________________ due to location.