



**If student has an open case with ACCES-VR, then the person cannot receive services through Pre-ETS.**

### Pre-Employment Transition Services Referral Form for Students with Disabilities

Initial request for services  Continuation of services

STUDENT NAME: \_\_\_\_\_  
(First) (Middle) (Last)

MAILING ADDRESS: (No., Street) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_

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  Work Based Learning Experience  Workplace Readiness Training to Develop social skills and independent living.
- Self-Advocacy Instruction/Self-Awareness  Counseling on opportunities for post-secondary education/training

Complete below information for initial request:

GENDER:  M  F  Unidentified Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
(if available)

RACE/ETHNICITY (check all that apply):

- Asian  American Indian/Alaska Native  Native Hawaiian/Pacific Islander \_\_\_\_\_
- Black/African American  Hispanic/Latino  White  Do not wish to answer

**By signing this form, I am requesting Pre-Employment Transition Services, from the Arc of 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.**

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.



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## Pre-employment Transition Services Referral Form for Students with Disabilities

### 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, 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:**

**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)

School Personnel Name    DATE: \_\_\_\_\_  
(Printed) (Signature)

**If this request form is being completed by non-school personnel, 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 L. Cramer**  
Pre-ETS Manager, Community Supports  
[mlcramer@arcofsteuben.org](mailto:mlcramer@arcofsteuben.org)

One Arc Way, Bath, NY 14810  
P: 607.776.4146 ext. 2213  
F: 607.777.9366  
[www.arcofsteuben.org](http://www.arcofsteuben.org) | Like us on [Facebook](#)

*Achieve with us.*

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(For Official Use Only)

Date Referral Received \_\_\_\_\_

Services will be provided through \_\_\_\_\_ due to location.