Kansas Rehabilitation Services Referral

Referral Date: ____________________ **Received by:** ________

Initial Contact made by (√)

___ **NAME:** ____
ADDRESS: ____
PHONE: ____________________ **DOB:** ____________________
SSN: ____________________

___ **REFERRAL SOURCE:** ____________________________________
PREVIOUS KRS CASE? ____________ **EMPLOYED?** ______________

Disability	Date of Onset

Check any agencies you are already getting services from:

Mental Health Ctr. (Cs Manager?) Alcohol/Drug Services Social Security SSI SSDI DCF
Kansas Works Rehabilitation Agency College Physician/Hospital Court Services/Probation

REASON FOR REQUESTING VOCATIONAL REHAB. SERVICES?

KS Rehabilitation Services 1701 Wheeler, Emporia, KS 66801 (620) 342-2505

FOR OFFICE USE ONLY

DATE OF SCHEDULED INTAKE: ____________________________________
Send letter of contact YES ___ NO ___
Send KRS Packet -KRS Application YES ___ NO ___ -KRS Handbook YES ___ NO ___
-Questionnaire & HA YES ___ NO ___
County of Residence: ______________ Counselor ____________________