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SPD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Employment 1st Program - Referral Form***

**Today’s Date:**

**Consumer’s Name:**

**Please include and email a copy of a current CSSP/CSP along with this referral.**

**Services being requested:**

**Employment 1st Program – Check box correlating with service requesting:**

**Employment Exploration**

**Employment Development**

**Employment Support**

**Finance & Benefits Services & Coaching**

**Address:**

**Phone:**

**Email:**

**Is this person able to meet virtually if needed?  Yes  No – If no, what are the barriers?**

**What City/Area(s) is the consumer targeting for work?**

**Are there currently any animals living in the home of this referral?**  **Yes**  **No**  **Unsure**

* **If Yes, please identify:**

**Primary Disability (ies):**

**PMI #:**

**Own Guardian/Legal Representative:  Yes  No**

**Guardian/Legal Representative Name and Phone Number:**

**Guardian Email:**

**Any scheduling conflicts to work around? (School/work/treatment/etc.):**

**Any potential challenges/barriers to finding work?**

**What type of work/employment is this person interested in?:**

**Current source(s) of income (SSI, SSDI, Wages, etc) and Amounts:**

**County of Residence:**

**Date of Birth:** **Gender:**  **Male**  **Female**  **Other**

**County Case Manager and Phone Number:**

**County Case Manager Email:**

**Waivered Service:**  **CADI**  **DD**  **TBI**  **DD/SILS**  **CDCS**  **Pending**  **None** **Other**

**Other Information that would be important to know in regards to this referral:**