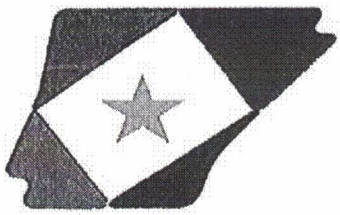

Arkansas Department of
Career Education

Arkansas Rehabilitation Services

Pre-ETS Student Referral Packet

What you need to refer a Pre-ETS student to your ARS Vocational Rehabilitation Counselor

- ☐ ARS Pre-ETS referral form
- ☐ Copy of student's Photo ID
- ☐ Copy of student's Social Security Card (or) Face sheet from School with student's social security number
- ☐ Signed ARS Informed Consent
- ☐ Benefits Consent form + SSA 3288
- ☐ Copy of student's IEP

ARKANSAS REHABILITATION SERVICES

INFORMED CONSENT

Client Name _____ _____
(Last) (First) (MI) Social Security Number

Authorization is hereby granted for referral of the above named individual to the Arkansas Rehabilitation Services. As parent/guardian I understand that in order to determine eligibility and services required to achieve a vocational goal, a comprehensive evaluation may be required. My signature authorizes the Arkansas Rehabilitation Services to conduct such an evaluation including medical, mental health, psychological, and/or vocational assessments.

Authorization is also granted to _____
(school, agency, clinic)

to release information in the record of the above named individual to the Arkansas Rehabilitation Services

(Counselor) _____

(Address) _____

_____

Type of information to be disclosed:
- ☒ Medical
- ☒ Psychological
- ☒ Vocational
- ☐ Other (specify) _____

Purpose for such disclosure:
- ☒ Establish eligibility
- ☒ Develop VR plan
- ☒ Determine treatment need/type
- ☐ Other (specify) _____

I understand the purpose(s) for which my consent is being requested. I understand that giving consent for the above stated purpose(s) is voluntary on my part and may be revoked at any time.

Consent to Media Publication:
The Arkansas Department of Career Education may reproduce images of students in print and electronic media in order to publicize the Department's mission of creating a job-ready workforce. Arkansas Rehabilitation Services, a division of the Department of Career Education, may publish information pertaining to its clients in connection with the administration of its vocational rehabilitation programs. If you permit reproduction and publication for these purposes, please sign this form and return it to your teacher, organization sponsor, or vocational-rehabilitation staff member. Permission for students or clients under the age of 18 must be indicated by the signature of their parent or

STUDENTS: I grant the Arkansas Department of Career Education permission to use and reproduce my image in print or electronic media (including video and social media). I understand that my image may be included in the Department's periodic publications, as well as in other public-relations materials including, but not limited to, press releases and news media.

_____ _____
Parent/Guardian Signature **Date**

STATE OF ARKANSAS

Asa Hutchinson
Governor

Department of Career Education
Arkansas Rehabilitation Services
D. Alan McClain, *Commissioner*

Charisse Childers, Ph.D.
Director

Pre-Employment Referral Form

REFERRAL SOURCE

Referral Source (School/services provider/ARS district field office): Superior Success Center **Referral Date:** _____

Referral Source Name (ARS counselor/school/service provider: **Dr. Renee Dawson**

Referral Source Phone number: **501-346-3255**

Pre-Employment Program: Self Advocacy, Post Secondary Counseling, Work Readiness

Student Information

LAST NAME: _____ **FIRST NAME:** _____

DOB: **PRIMARY PHONE:**

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

STUDENT'S E-MAIL: _____ **STUDENT'S CELL PHONE:** _____

PARENT/GUARDIAN'S PHONE: _____

PARENT/GUARDIAN'S E-MAIL: _____

REFERRAL INFORMATION

STUDENTS' ANTICIPATED GRADUATION DATE: _____

Students Primary Disability: _____

Students Secondary Disability: _____

CHECK AND ATTACH COPIES OF THE FOLLOWING DOCUMENTS:

☐ Current IEP/504 plan ☐ Copy of Social Security Card

☐ Transition Assessment(s) ☐ Release of Information/informed Consent

PLEASE CHECK ALL THAT APPLY:

☐ Hearing Loss ☐ Emotional/Mental Health ☐ Physical/Orthopedic Limitations

☐ Speech/Communication limitations ☐ Cardio/Respiratory Limitations ☐ Learning Disabilities

☐ Autism Spectrum Disorder ☐ Other

Arkansas Rehabilitation Services

Pre- Employment Referral Form

Describe Limitations (if any):

What are the student's post-secondary goals for employment, training, or post-secondary education?

Does Student have access to transportation: ☐ Yes ☐ No

Does student have any work experiences: ☐ Yes ☐ No ☐ N/A

If Yes, describe student's work experiences:

Are there any circumstances that will limit students availability to participate in the Pre-employment transition program (medical appointments, custody arrangements, school schedule, etc.) ?

☐ Yes ☐ No

If yes, please explain:

Is student receiving services from other disability service providers (Medicaid waiver, AR Promise, etc) ?

☐ Yes ☐ No

If yes, please list all services providers working with student :

Please list any additional information you feel is important and relevant for the service provider, counselor, or staff regarding the student:

Arkansas Rehabilitation Services
Pre-employment Referral Form

Pre-Employment Referral Form

- The ARS Pre-ETS referral form is intended to be utilized as a universal referral form for all partners in referring students for Pre-ETS services
- The referral form maybe used for educators to refer student to ARS for Pre-Employment Transition Services
- The referral form maybe used for ARS Transition Counselor to refer a student to a Pre-Employment program

BENEFITS PLANNING

Dear Parent/Guardian,

Your student has an exciting opportunity to earn wages while participating in a pre-employment program during high school. Because wages can impact Social Security and other benefits, it may be advantageous to work with a benefits planning specialist. The goal of working with a planning specialistis to maintain your student's benefits *(both cash payments and medical coverage)* while he or she earns wages through the pre-employment work experience program.

Attached is Form 3288, which allows the Social Security Administration to release certain information about your student to a qualified benefits planning specialist. Once this information is received, the planner will produce a benefits summary and analysis, which will guide you and your student on the types of benefits received (Social Security, Medicaid waiver, or other federal benefits, for example) and how to maintain them while working. The benefits planning specialist will also see what other work incentives your child may be eligible for to help your child be as successful as possible upon graduation of high school

Please check one of the boxes below. Thank you!

☐ ACCEPT ASSISTANCE OF BENEFITS PLANNER

I consent to the assistance of a qualified benefits planner, who will work to maintain the benefits paid to my student while he or she participates in the pre-employment work experience program. I will complete the attached Form 3288.

☐ DECLINE ASSISTANCE OF BENEFITS PLANNER

I do not consent to the assistance of a qualified benefits planner. I understand that my student may face a reduction in benefits while he or she participates in the pre-employment work experience program.

Student Name _____

Students High School _____

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

The pre-employment work experience program is coordinated and sponsored by Arkansas Rehabilitation Services, a division of the Arkansas Department of Career Education. The benefits planning referred to above will be administered by Project AWIN, a benefits-planning project approved by the Social Security Administration.

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
PROJECT AWIN	PO Box 242360
Cathy Coker	Little Rock, AR 72233

*I want this information released because: I am planning to go to work and need the information for benefits and work incentives planning. Please send a Benefits Planning Query.

We may charge a fee to release information for non-program purposes.

*Please release the following information selected from the list below:

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.

7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)

   My cash benefits, health insurance information, medical review dates, representation, SSDI and SSI work activity and earnings. All employment supports data on my SSA record.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

*Signature: _____ *Date: _____

*Address: _____

Relationship (if not the subject of the record): _____ *Daytime Phone: _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a quired field).*

): Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
PROJECT AWIN	PO Box 242360
Cathy Coker	Little Rock, AR 72233

***I want this information released because:**
We may charge a fee to release information for non-program purposes.
I need this information for program purposes,

***Please release the following information selected from the list below:**
You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
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6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
   ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**
   Non-certified yearly totals of earnings.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)