

Referral taken by: _____
Phone _____ Mail _____ Email _____
Walk-In _____ Fax _____

dvr
Department of Labor & Workforce Development
DIVISION OF VOCATIONAL REHABILITATION SERVICES
550 Jersey Avenue, New Brunswick, NJ 08901
Telephone: (732) 937-6300 *(732) 937-6358

"OO" Closure #: _____
Regular Closure #: _____
Screened by: _____ Date _____

Name _____ Date _____

Address _____ County _____

City _____ NJ Zip _____ Telephone _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

BIRTH DATE ____/____/____ SEX ____ AGE ____ Highest grade completed in school? _____

English speaking? (Y or N) ____ Spanish speaking? (Y or N) ____ Veteran? (Y or N) ____ US Citizen? (Y or N) ____

If no, do you have documentation to work? ____ (Y or N) Registered with Div of Dev Disabilities (DDD)? (Y or N) ____

Disability _____? Are you physically able to come to this office? ____

Have you ever applied to DVRS before? (Y or N) ____ If yes, when/where? _____

Do you receive Social Security Benefits? (Y or N) ____ SSD ____ SSI ____ Welfare Benefits? (Y or N) ____

TANF/GA case number _____ TANF/GA case worker _____ Phone number _____

REFERRAL SOURCE: Name _____

Organization _____ Phone Number _____

Address _____

Reason for referral: _____

If records documenting disability are available, please include with referral to expedite eligible process.

(BELOW FOR DVRS USE ONLY)

ASSIGNED TO COUNSELOR: _____ DATE _____

APPOINTMENT DATE & TIME: _____

Assigned to Counselor ____ or Walk-In Assigned to COD ____ Date: ____/____/____

Appointment Date & Time _____

OO CLOSURE DATE: _____ REASON: _____

NOT ASSIGNED DATE: _____ REASON: _____