

Steven A. Penge
Guidance/Transition Planning
Special Education Department
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Please fill out the following form for any student you would like referred to this program. Students will be reviewed as slots become available and referred based on priority of need and readiness to benefit from the service. Please include any information that will support this referral in the "Reason for Referral" section below. Please complete the attached questionnaire along with the current IEP, Psycho-Educational Evaluation, Health Record and any information pertinent to the student's educational program and submit it to the Guidance Office.

Arc School-To-Work Referral

Last Name: _____ First Name: _____ Date: _____

Address: _____

City: _____ State: NY Zip: _____ Phone: _____

DOB: _____ Classification: _____

Placement: _____ Teacher: _____

Location AM: _____ Location PM: _____

VESID Status: Open Not Open Date Referred: _____ Counselor: _____

Services Requested:

Assessment Shadowing Internships

Job Development Coaching

Facilitate Transition to Sheltered Facilitate Transition to Day Services

Reason for Referral: _____

Admin. Approval Date: _____ Intake Meeting: _____

**BOCES/Options Unlimited
School to Work Referral Form**

Student Name: _____

Expected Graduation Date: _____

Teacher: _____

Academic Program: _____

Post Graduation Plans: _____

Vocational Goal(s): _____

Employment History: _____

Attitude Towards Work:

 Paid: _____

 Unpaid: _____

Family's Attitude Towards Work: _____

Transportation Needs: _____

School Attendance: _____

Behavioral Concerns:

 In School: _____

 Out of School: _____

Legal History: _____

In your own (Student's) words, state why you would like to work with the School to Work Program and what would you hope to get out of the Program? _____

Signature of Referring Person: _____

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Vocational and Educational Services for Individuals with Disabilities (VESID)

Authorization to Release / Obtain Information

VES-22 (09/03)

CONSUMER NAME: _____

CONSUMER ID NUMBER: _____

CONSUMER ADDRESS [include street (apartment number or building, if applicable), city, state, zip]

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) has my permission to release or obtain information indicated in item #1 below. This information may include reports about my physical or mental condition, school records, facts necessary to determine my financial need, or other information that VESID needs to determine my eligibility and to provide vocational rehabilitation services. I understand that this information will be treated as confidential and privileged and will only be used for the purpose of obtaining services offered through VESID.

I can change my mind about this release, by telling VESID in writing that I do not want any further information to be given out. I understand that information disclosed according to this consent may be subject to redisclosure and will no longer be subject to the HIPPA privacy requirements. This will not affect actions already taken with my permission.

My permission to release or obtain information expires on date _____ or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released or obtained? (Be specific.)

Transcripts, Vocational Assessment, Psychological, Psychiatric (if available), IEP, Health Record, Social History, PT/OT/Speech Record

2. Who is releasing this information? (Insert the full name of this person or organization.) Oneida County BOCES
Special Education Department

3. Who is receiving this information? (Insert complete information about this person.)

Name: Ann Colgan; Joanne Donaruma

Title: VESID Counselor; ARC Supported Employment Director

Address: Genesee St. State Office Building, Utica, NY 13501; 245 Genesee St., Utica, NY 13502

4. Why is this information needed?

To facilitate the implementation of Transition planning and delivery of services.

I have read all of the information on this form. I understand and agree to what it says.

Consumer or Parent/Guardian Signature: _____ Date: _____

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records. Form VES-540, Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Alcoholism or Substance Abuse, must be attached to this form when necessary.

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