Kansas Department for Children and Families
Rehabilitation Services

Transition Notification
Referral for Vocational Rehabilitation Services

From: School _____

Address _____

Phone _____

Responsible Local Education Authority Staff _____

To: Local Rehabilitation Office Phillipsburg DCF Office

Address 111 E. Hwy 36, Phillipsburg, KS 67661

Phone 785-543-5258 ext. 239

ATTN: (Counselor Name) Danielle Elliott

Student: Name _____

Address _____

Phone _____

Social Security Number _____

Birth Date _____

Expected Date to complete or exit school _____

Notification Accompanied by:

- Signed release of information
- Current IEP
- Current Three year evaluation
- Psychological testing information as recent as age 16 if available.

CONSENT FOR REFERRAL/RELEASE OF INFORMATION

Below is the signature authorization for _____ to be referred for Vocational Rehabilitation Services. I hereby consent to the release of the information to be sent to Rehabilitation Services for vocational rehabilitation planning.

Signature of Student _____ Date_____

* Signature of Parent/Legal Guardian (if appropriate) _____ Date_____

* If signed by parent/legal guardian, please provide address and phone number if different than the student's.

Address: _____

Phone: _____

Reasonable accommodations needed: _____