**Massachusetts Rehabilitation Commission**

**Statewide Employment Services Department**

**Individual Members Planning and Assessing Choices Together**

**Project IMPACT**

**1-800-734-7475**

**Fax (617) 204-3847**

**INTAKE REFERRAL FORM**

Benefits Specialist: Click here to enter text.

Date: Click here to enter text.

Referral Source Name: Click here to enter text.

Description of Service: Click here to enter text.

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**CLIENT INFORMATION**

**Is this client still enrolled in high school?** [ ] **YES** [ ] **NO**

**Receiving: ( ) SSI $**Click here to enter text. **( ) SSDI $** Click here to enter text.

**( ) VA Pension $**Click here to enter text. **Compensation $** Click here to enter text.

Name: Click here to enter text. D.O.B. Click here to enter text.

Address: Click here to enter text.

City: Click here to enter text.ZIP: Click here to enter text.

Phone: Click here to enter text. Email: Click here to enter text.

SSN#: Click here to enter text. Rep Payee: Click here to enter text.

Is Client Working? [ ] YES [ ] NO Start Date: Click here to enter text.

Employer Information: Click here to enter text.

Additional Information: Click here to enter text.

