Check box ☐ For Transition Consumer

MassAbility

REQUEST FOR AT SERVICES

Client Information: **Date of Referral:**

Name: Last / First / M. I.	**Date of Birth:** Month/ Date/ Year
Address: Street / Apt No. / City / State / Zip Code	
Phone: Home / Work / email:	**Contact Person:** **Phone:**

Eligibility: ☐ VR ☐ IL Service Programs ☐ BISSC ☐ Homecare ☐ Other :

VR ONLY	**Case Status:**	**CASE #**	**Vocational Goal:**

Referral Source:

Name: Last / First	**Office Location:**
Phone: **FAX:** ***email*:**	

Select Adaptive Assistance Service Provider :
☐ MA Easter Seals ☐ UCP of Berkshire County, Inc.

Referral Information:

Primary Disability ____________________

Functional Limitations:

Secondary Disability ______________________

Functional Limitations:

Additional Comments:

Services Requested: ☐ Alternative Computer Access ☐ Augmentative Communication

☐ Ergonomics ☐ Environmental Controls ☐ Other (specify): ________________

☐ Initial Eval.

Clinical/Therapy Reports Enclosed if any:

☐ **Physician**	☐ **Physical Therapy**	☐ **Occupational Therapy**
☐ **Speech Therapy**	☐ **Vocational Evaluation**	☐ **Eye Exam**
☐ **Neuropsychology**	☐ **Audiology Exam**	☐ **Other:**

Date Received:	**Comments**

Purpose of Adaptive Assistance:

Financial Need Determination Completed: __Yes ___ No Client is SSI/DI Eligible: __ Yes __ No

Client has cost share: ___ Yes ___ No
Client contribution towards adaptive assistance services: $_____________

Counselor Signature: ___________________________________ **Date:** ________________

Area Director Signature: ________________________________ **Date:** ________________

For Rehabilitation Technology program use only:

Date Received:	Equipment: Training Hours: Estimated cost of services (if known):

Please email requests to: Julian.Concannon, Occupational Therapist
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