STAR Referral Form – (District)

Name: _____ SS#: _____

Date of Birth: _____ Gender: _____ Disability Documentation: _____

Home address: _____

City: _____ Zip Code: _____ County: _____

Phone Number: _____ Email: _____

Name of School: _____

Parent/Guardian Information (if applicable)

Name: _____

Home Phone, if different from student: _____ Cell: _____

Email: _____

School Staff Making Referral

Name: _____

Email: _____ Phone: _____

Accommodations for initial STAR meeting with VR Staff:

Do you require an American Sign Language interpreter? ☐ Yes
Do you require an assistive listening device? ☐ Yes
Do you required translated documents? ☐ Yes
Do you require a foreign language interpreter? ☐ Yes
Do you require any other accommodation for your impairment? ☐ Yes
If yes, please explain: _____

Transition Youth Services Requested (Check all that apply)

☐ Career Exploration Counseling (includes skills, abilities, aptitudes, interest assessments, and postsecondary counseling)

☐ Work Readiness Training (A 20 hour course that focuses on employability and work readiness skills)

☐ Self-Advocacy Training (A two-part course that teachers students how to speak up for themselves and make decisions

about their own lives)

☐ Community Based Work Experiences (includes hands on training for employability skills; may be paid or non-paid)

Signature Page

Student Acknowledgement

I understand that through Vocational Rehabilitation STAR services, I will be offered limited Pre-Employment Transition Services that can help me explore, prepare for, and make informed career-based decisions. I understand that I must be an active participant in the services I choose to achieve my transition goals.

_____ _____
Signature of Student Date

Permission to Make Referral

By Signing this STAR Referral, I give _____County Schools permission to submit this STAR Referral to VR. I understand I will be contacted by VR Staff to set up an initial meeting and acknowledge that my participation is required if my child is under 18 or if I am his/her Guardian.

Parent/Guardian/Age of Majority Student: _____ _____
Signature Date

Confirmation Statement

By Signing this STAR Referral, I confirm that the student has been identified by _____County Schools as a student with a disability.

School Staff: _____ _____
Printed Name Position

_____ _____
Signature Date

Type of Disability Documentation being submitted: _____

Name of school staff submitting the referral to VR Staff: _____

For Official VR Use Only (to be completed by VR Staff)

VR Youth Tech's Name: _____ Area: _____ Unit: _____

Date referral received from SDR: _____

Date entered into STAR: _____