

Request for Services - Goodwill of the Heartland

Employment Services - Davenport
121 W Locust, Suite 300
Davenport, IA 52803
(563) 327-0150 Fax: (563) 823-0185

Employment Services – Muscatine
2001 Cedar Plaza Drive
Muscatine, IA 52761
(563) 263-2826 Fax: (563) 263-2826

Instructions. Complete both pages upon referral to the initial Goodwill service. Submit with documentation of disability and appropriate referral information. Thank you for this referral.

Name _____ **Date** _____
(last) (first) (m.i.)

Address _____ **Phone** _____

Date of birth _____ **SS#** _____ **SSI:** \$_____/mo. **SSDI:** \$_____/mo.

Guardian _____ **Address** _____ **Phone** _____

Disability: Primary _____ **Secondary** _____

Identified strengths _____

Identified barriers _____

Medications _____

Are specific workplace accommodations desired? No Yes

If Yes, please explain _____

History of aggression toward self, others and/or property: No Yes Unknown

Residential Status: Independent Family/friends Programming _____

Vocational History: Currently working Worked previously, not currently Never worked

Employer _____ **Job** _____ **Dates** _____

Employer _____ **Job** _____ **Dates** _____

Employer _____ **Job** _____ **Dates** _____

County of Legal Settlement _____ **Previously at GW?** No Yes Unknown

Educational Information (post secondary, secondary, special ed., GED, etc.)

Referring Agency _____ **Address** _____

Phone _____ **Fax** _____

Referring Person _____ **Title** _____

(signature)

Addendum to Request for Services Goodwill of the Heartland

(IVRS: submit a new *Addendum* when referring for a subsequent Goodwill service or group of services. Thank you.)

	Client	Referring Agency	Referring Counselor
Service Request:	<u>IVRS:</u>	<input type="checkbox"/> D1 <input type="checkbox"/> D2/D3 <input type="checkbox"/> D5 <input type="checkbox"/> D7 <input type="checkbox"/> D8 <input type="checkbox"/> D9 <input type="checkbox"/> D10 <input type="checkbox"/> D11 <input type="checkbox"/> D12 <input type="checkbox"/> D13	
		<input type="checkbox"/> D14 <input type="checkbox"/> D15 <input type="checkbox"/> D15A <input type="checkbox"/> D15B <input type="checkbox"/> D16/D17 <input type="checkbox"/> D18/D19 <input type="checkbox"/> D20 <input type="checkbox"/> D21/D22/D23	
		<input type="checkbox"/> ACCESS (Assistive Technology) Evaluation/Training/Other (Iowa City Only)	
Counties & Others:		<input type="checkbox"/> Supported Employment <input type="checkbox"/> Enclave <input type="checkbox"/> Sheltered <input type="checkbox"/> Work Activity	
		<input type="checkbox"/> Day Habilitation (Iowa City Only)	
Hab. Or HCBS:		<input type="checkbox"/> Job Coaching <input type="checkbox"/> Activities to obtain Job <input type="checkbox"/> Enclave <input type="checkbox"/> Prevocational	
	Title XIX #:	_____ <input type="checkbox"/> Day Habilitation (Iowa City Only)	
	County of Legal Settlement:	_____	

Client preferences/work requests

Specific referral questions (for assessment services) or training objectives (for other services)

- 1.

- 2.

- 3.

Employment goal (type of job, hours per week, etc.)

Persons to be included on the Interdisciplinary Team

Comments

Referring Person _____
(signature)

Date _____