

ST CLOUD

(320) 227-1305 FAX (320) 227-1309

TO REFER: Please return completed referral form and disability related or medical information to:

Carrie Stang, MRC St Cloud
3400 First Street North #404, St Cloud, MN 56303

INTAKE

ASSESSMENT SERVICES

- Career Compass
- Course 1 Course 2 Course 3
- Transferrable Skills Assessment
- Community Based Assessment/Job Tryout – Industry/job requested: _____
- Corporate Visit/Job Shadow – Industry/Job requested: _____
- Transportation Assessment & Coaching
- Other: _____

EMPLOYMENT RELATED SERVICES

- Placement
- Extended Employment
- Worksite Support
- Other

TRAINING AND EDUCATION SERVICES

- Accounting Support Training Program
Entrance Assessment
Workplace Essentials Training
Business and Computer Applications Specialist Training
Accounting Support 101 Training
- Medical Office Support Training Program
Entrance Assessment
Workplace Essentials Training
Business and Computer Applications Specialist Training
Healthcare Technician Training
- Contact Center Training Program
Entrance Assessment
Workplace Essentials Training
Contact Center 101 Training
- Office Support Specialist Training Program
Entrance Assessment
Workplace Essentials Training
Business and Computer Applications Specialist Training
- Workplace Essentials Training

- Industry Certification Preparation Courses
- Microsoft Office Specialist 2010 Certification Prep & Exam (MOS)
 Word Excel PowerPoint
- Special Engineer (Boilers) License Prep & Exam
- Certified Pool Operator (CPO) Certification Prep & Exam
- Other: _____

- One-to-One Computer Training
Focus: _____

Intro and Intermediate Short-term Training:
Please list classes:

PARTICIPANT NAME: _____ **SOCIAL SECURITY NUMBER:** _____

ADDRESS: _____ **APT #:** _____ **EMAIL:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **MESSAGE PHONE:** _____

RACE: _____ **SEX:** _____ **DATE OF BIRTH:** _____ **AGE:** _____ **TRANSPORTATION:** CAR BUS METROMOBILITY

TOTAL # OF INDIVIDUALS IN HOUSEHOLD: _____ **BREAKDOWN = ADULTS (18+)** _____ **CHILDREN W/AGES:** _____

PERSON TO CONTACT IN AN EMERGENCY: _____

RELATIONSHIP _____ **PHONE** _____

DISABILITY: YES NO **US CITIZEN:** YES NO **VETERAN:** YES NO **IMMIGRANT:** YES NO

PHYSICIAN: _____ **MEDICATIONS:** _____

PRIMARY DISABILITY: _____

SECONDARY DISABILITY: _____

JOB RELATED LIMITATIONS: _____

REASONABLE ACCOMMODATIONS ARE PROVIDED UPON REQUEST – PLEASE LIST NECESSARY ACCOMMODATIONS: _____

FELONY CHARGES: YES NO **DESCRIPTION:** _____

MISDEMEANOR CHARGES: YES NO **DESCRIPTION:** _____

DATE (S): _____ **PROBATION OFFICER:** _____ **PHONE:** _____

MRC ST CLOUD REFERRAL FORM

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Complete all applicable information.

PARTICIPANT: _____

******MANDATORY: ALL REFERRING COUNSELORS/AGENCIES ARE TO COMPLETE #1******

#2 – COMPLETE IF PAYMENT SOURCE IS DIFFERENT/IN ADDITION TO REFERRING COUNSELOR.

#3 – COMPLETE FOR RESOURCE INTERNAL REFERRALS

#1

REFERRING COUNSELOR: _____ PHONE: _____ REFERRAL SOURCE/AGENCY: _____ ALTERNATE CONTACT FOR COUNSELOR/VR TECH: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
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#2

<i>BILL PAYMENTS TO (IF DIFFERENT THAN/IN ADDITION TO REFERRAL SOURCE)</i>	
CONTACT: _____	COMPANY NAME: _____
PHONE: _____	CLAIM NUMBER: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP: _____
FAX: _____	EMAIL: _____

#3

<i>RESOURCE INTERNAL REFERRAL - RESOURCE Staff Use Only</i> COMPLETE AND ATTACH: RESOURCE TRAINING AUTHORIZATION FORM FOR MRC SERVICES <i>Located on Intranet under Accounting Forms</i>	
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CURRENT PARTICIPANT EMPLOYMENT INFORMATION:	
EMPLOYER: _____	ADDRESS: _____
WORK PHONE: _____	EMPLOYMENT START DATE: _____
CURRENT HOURLY WAGE _____	# OF HOURS PER WEEK _____ HEALTH BENEFITS ___ YES ___ NO
JOB DUTIES: _____	
CONCERNS ABOUT EMPLOYMENT SITUATION: _____	

HAS DISABILITY BEEN DISCLOSED TO EMPLOYER? _____	
SUPERVISOR: _____	SUPERVISOR PHONE: _____

COMMENTS: _____

REFERRING COUNSELOR SIGNATURE: _____ **DATE:** _____