

Partnering for Jobs

Collaborative Partners:

Lifetrack Resources, Canvas Health, Vocational Rehabilitation Services and Washington County

Referral Form

Send to **Amanda Lor** interoffice mail to Canvas Oakdale or Canvas Health | Attn: Amanda Lor | 7066 Stillwater Blvd. Oakdale, MN 55128 | EMAIL: alor@canvashealth.org

Referral Date: _____ Referring Person: _____

Referral Agency and Phone: _____

Name: _____ Address: _____

Male Female Non-Binary TransMan TransWoman Gender nonconforming Other, not listed Decline to Answer

Preferred Pronouns: He She They Ze No pronoun preference a pronoun not listed: _____

Phone H C: _____ (e-mail) _____ Date of Birth: _____

Guardian: Y N Name: _____ Phone: _____

Mental Health Diagnosis: _____ Age of Onset: _____

Secondary Disability: _____

Criminal History: Y N Current Charges: _____

Probation Officer: Y N Name: _____ Phone: _____

<p><u>EDUCATION LEVEL:</u></p> <input type="checkbox"/> Not Known <input type="checkbox"/> Jr. High <input type="checkbox"/> H.S./GED <input type="checkbox"/> Some College <input type="checkbox"/> Some Vo Tech <input type="checkbox"/> College <input type="checkbox"/> Spec. Ed <p>____ Total Years of Ed.</p> <p><u>RESIDENTIAL STATUS:</u></p> <input type="checkbox"/> Independent <input type="checkbox"/> Nursing Home <input type="checkbox"/> Parent/Family <input type="checkbox"/> Residential Facility <input type="checkbox"/> Supported Housing (SILS) <input type="checkbox"/> Other <p><u>RACE:</u></p> <input type="checkbox"/> African American <input type="checkbox"/> African Immigrant <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Latino <input type="checkbox"/> Multi-Racial <input type="checkbox"/> White <input type="checkbox"/> Unknown/Not Stated <p>U.S. Citizen <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>National Origin: _____</p> <p>Immigrant Status _____</p>	<p><u>MARITAL STATUS:</u></p> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Single Parent <p><u>EMPLOYMENT HISTORY:</u></p> <input type="checkbox"/> Competitive <input type="checkbox"/> Volunteer <input type="checkbox"/> Military Service <input type="checkbox"/> None Reported <p><u>INCOME/BENEFIT SOURCE:</u></p> <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Employment <input type="checkbox"/> Family <input type="checkbox"/> Food Stamps <input type="checkbox"/> General Assistance <input type="checkbox"/> Housing Subsidy <input type="checkbox"/> MAEPD <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare B <input type="checkbox"/> MFIP/TANF <input type="checkbox"/> MN Care <input type="checkbox"/> MSA <input type="checkbox"/> MN Care <input type="checkbox"/> Pension <input type="checkbox"/> SSDI <input type="checkbox"/> SSI/MA <input type="checkbox"/> Soc. Sec. Retirement Benefits <input type="checkbox"/> Survivor Benefits <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other _____	<p><u>TRANSPORTATION:</u></p> <input type="checkbox"/> Own Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Transit Link <input type="checkbox"/> Other <p><u>MEDICAL RESTRICTIONS/LIMITATIONS:</u></p> <p>_____</p> <p><u>ALLERGIES:</u></p> <p>_____</p> <p><i>Identify active service and provider:</i></p> <p>ARMHS:</p> <p>Psychiatry:</p> <p>Day Treatment:</p> <p>Out Patient:</p> <p>Other:</p>	<p><u>QUESTIONS:</u></p> <p>Call Sierra Dooley Phone: 651-338-7559 Fax: 651-251-5110 Email: SierraD@lifetrack-mn.org</p> <p><u>NOTES:</u></p> <p><i>(Admin only)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Locus <p>Client ID: _____</p> <p style="background-color: yellow; text-align: center;">Complete Back Side</p>
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Partnering for Jobs

Canvas Health Referral Information- This form is to be filled out by the referring Canvas Health therapist, ARMHS provider, Psychiatrist, or Adult Case Manager. This information will be used in order to appropriately engage your client in Vocational Services through the Partnering for Jobs Program. After talking with your client about this program, complete this referral packet; the Primary PJ Referral Form, your answers to these questions, and the completed Releases of Information for MN Vocational Rehabilitative Services, and Lifetrack Resources. Send this packet to Amanda Lor at Canvas Oakdale via interoffice mail or by email.

1. Please include some information about your client's mental health symptoms and how they might affect a job?
2. What is your client currently saying about work (their motivation, readiness to take active steps towards competitive employment part-time or full-time)?
3. What do you see as your client's strengths regarding work (experience, personality, supports etc.)?
4. What job (type, hours, etc.) do you think might be a good match for your client?
5. How might be best partner together in order to enhance your work with your client and lead to a successful job match (e-mails, meetings, etc)?