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|  | “*People*  *helping people*  *help*  *themselves”* | ***Division of Disability and Rehabilitative Services***  ***Vocational Rehabilitation***  ***Authorization Request Form*** |

*Complete the following optional form to request an authorization for services. Send completed form to local VR Area Office E-mail.*

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| **Participant Name:** | Participant name. | **VR Identification Number:** | Enter VR ID. |
| **Employment Consultant (EC):** | Employment Consultant | **Agency:** | Enter agency name. |
| **EC e-mail:** | EC Email. | **Date of Request**  ***(month, day, year)*:** | Select date. |
| **Send authorization to:** | Send authorization to. | | |

**Request 1:**

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| Service / CC Code: | Other-Please note below in Additional Comments |
| Duration:  3 months  6 months | Requested Start Date *(month, day, year)*: Select start date. |
| If hourly service, number of hours: | If non-hourly service, number of units: |
| 20 Hours 40 Hours  60 Hours 100 Hours | Enter number of units. |

Reason for Request: Enter reason here.

Additional Comments: Enter additional comments here.

**Request 2:**

|  |  |
| --- | --- |
| Service / CC Code: | Choose an item. |
| Duration:  3 months  6 months | Requested Start Date *(month, day, year)*: Select start date. |
| If hourly service, number of hours: | If non-hourly service, number of units: |
| 20 Hours 40 Hours  60 Hours 100 Hours | Enter number of units. |

Reason for Request: Enter reason here.

Additional Comments: Enter additional comments here.