WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
DIVISION OF FAMILY ASSISTANCE
REFERRAL FOR TRAINING / SERVICES

DATE: _____ COUNTY: _____

The Department of Health and Human Resources is referring the individual named below for services/enrollment in and/or interview for:

☐ ABE/GED ☐ Community Access ☐ SPOKES / EXCEL
☐ Rehabilitation Services (DRS) ☐ One Stop Center / BEP
☐ Other Training/Service: _____

INDIVIDUAL'S NAME: _____

REPORT TO: (Name and Address of Training Site or Referral Agency)

_____

_____

CONTACT PERSON: _____

_____

DATE: _____ TIME: _____ TELEPHONE: _____

INFORMATION NEEDED/COMMENTS: _____

_____

_____

_____
DHHR Office Address

_____ _____
Phone Number Signature - WV WORKS Staff

- -

Please Complete This Section and Return Entire Yellow Copy to the Above DHHR Staff Member

Participant's Name: _____

Date Interviewed for Training/Program: _____

Scheduled Start Date For Training/Program: _____ Enrolled?: Y ___ N ___

Comments: _____

_____

_____
Signature Of Services/Training Representative

DFA-WVW-70
(New 3/04)

White - Referral Agency Copy Yellow - Copy Returned to DHHR Pink - Case File Copy