WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Referral for Vocational Assessment

DATE: _____ COUNTY: _____

To:	**From: Dept. of Health & Human Resources**
Address:	Address:
Contact Person:	Contact Person:
Phone:	Phone:
	Worker's E-Mail:

WV WORKS Participant's Information

Name: _____

Address: _____

PIN Number: _____ Phone: _____

Mark any of the following which have already been completed for the above named participant and provide the test results with the referral form. NOTE: Completion of the EHI and LNS are voluntary. TABE and Work Keys may not be required for all individuals. See IMM Section 24.4,C.

- ☐ Test of Basic Education (TABE)
- ☐ Emotional Health Inventory (EHI)
- ☐ Learning Needs Screening (LNS)
- ☐ Work Keys
- ☐ Medical Review Team (MRT) Packet
- ☐ Personal Responsibility Contract (PRC)
- ☐ Initial Self-Sufficiency Appraisal (OFA-WVW-3A)
- ☐ Other – Specify _____

Availability of Participant for Assessments

Can the participant complete testing at the designated agency field office? ☐ Yes ☐ No

Can the participant sit several hours at a time to complete a vocational assessment? ☐ Yes ☐ No

Other Comments: _____

Participant Meets One or More of the Following Criteria

- ☐ Unable to work for more than six months due to physician's statement.
- ☐ Determined incapacitated for WV WORKS by the MRT and a referral to DRS is indicated on form ES-RT-3.
- ☐ TABE scores 12 and above in Sections A-D of the LNS or answers "yes" to question #13 in Section D.
- ☐ Received TANF/WV WORKS for **36** months or more.
- ☐ WV WORKS Supervisor and Worker have determined individual would benefit from assessment.

I give my permission for the WVDHHR Division of Family Assistance to share the above information with the vocational assessment provider concerning my eligibility for this program.

_____ _____
Participant's Signature Date

_____ _____
WV WORKS Supervisor's Signature Date

DFA-WVW-80 (Rev. **7/11**)

Original - Provider Copy – Case Record Copy - Participant