State of California – Health and Human Services Agency
EMPLOYMENT SERVICES REFERRAL
DS 1968 (Rev. 01/2026) – Electronic Version

Department of Developmental Services
TYPE OR PRINT LEGIBLY

Estimated Start Date:

Individual Information

UCI NUMBER			
LAST NAME	FIRST NAME	INDIVIDUAL EMAIL	
MAILING ADDRESS	CITY	ZIP CODE	PHONE
CONSERVATOR/ PARENT LAST NAME	FIRST NAME		PHONE
MAILING ADDRESS	CITY		ZIP CODE
CURRENT PROGRAM	PRIOR PROGRAM		

Individual Referral Choice

VR ☐

PREFERRED PROVIDER NAME

OFFICE VR COUNSELOR NAME	OFFICE VR COUNSELOR EMAIL

SEP – IP ☐	PIP or SIP ☐	CES ☐	No Preference (at this time) ☐				
	REQUIRED:		Most Recent (if available):				
REPORTS ATTACHED	CDER ☐	IPP ☐	MED ☐	PSY ☐	SOC ☐	SSI ☐	SSDI ☐
REPORTS SENT TO VENDOR	CDER ☐	IPP ☐	MED ☐	PSY ☐	SOC ☐	SSI ☐	SSDI ☐

CERTIFICATION

I certify that according to the Individual Program Plan (IPP) this individual requires employment services. I am referring this person for services and understand that a determination of initial eligibility to confirm the need for services shall depend on findings from an evaluation. This person is eligible for regional center's habilitation extended services and other employment related services specified in the Individual's IPP.

RC Name	RC Representative (PRINT)	RC Representative (SIGN)	Date
Address		City	Zip Code
Phone Number	Fax Number	Email Address	

I understand that in the course of providing employment services to me, this information will be shared with the Department of Rehabilitation and the applicable service providers. I agree to have the regional center pay for the services that may result from this referral.

Individual's Signature	Conservator's Signature	Date
Witness Name (If Necessary)	Witness Signature (If Necessary)	Date

NOTICE

The information provided in these documents is protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). Reasonable and appropriate safeguards must be implemented to protect the confidentiality and integrity of this information in any format as well as during transmission in electronic format as applicable.

The Department of Developmental Services affirmatively supports all federal and state civil rights laws and will not knowingly do business with any agency or entity which discriminates based on ethnic group, sexual orientation, physical or mental disability, medical condition, marital status or ancestry.

If referral is for VR, distribution is as follows:

ORGINAL – VR Office COPY 1 – Regional Center File COPY 2 – VR Service Provider COPY 3 – Individual

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Functional Limitations and Support Needs

To assist with VR eligibility and planning, the following can be used, as applicable. Rate each based on the individual's current level or limitation. Check one level per category and add notes if needed.

Category	Description	Level of Limitation				Notes
Communication	Has difficulty reading, writing, speaking, listening, or understanding information.	None ☐	Mild ☐	Moderate ☐	Severe ☐	
Interpersonal Skills	Has challenges interacting with others, interpreting behavior, or working with coworkers or supervisors.	None ☐	Mild ☐	Moderate ☐	Severe ☐	
Mobility	Has difficulty walking, standing for long periods, using stairs, or moving safely from one place to another.	None ☐	Mild ☐	Moderate ☐	Severe ☐	
Self-Care Home Care	Needs support with personal care tasks such as grooming, dressing, eating, bathing, or daily routines.	None ☐	Mild ☐	Moderate ☐	Severe ☐	
Self-Direction	Has difficulty making decisions, organizing tasks, or following through on plans.	None ☐	Mild ☐	Moderate ☐	Severe ☐	
Work Skills	Has difficulty learning or performing job tasks, following directions, or adjusting to new work routines.	None ☐	Mild ☐	Moderate ☐	Severe ☐	
Work Tolerance	Has difficulty maintaining focus, stamina, or a consistence work pace throughout the day.	None ☐	Mild ☐	Moderate ☐	Severe ☐	