

EMPLOYMENT SERVICES REFERRAL

DS 1968 Instructions (New 1/2026)

INSTRUCTIONS ONLY

GENERAL INFORMATION

This is a form consisting of two pages. If you are unable to see the form, click on the maximize button (the center button) located in the upper right hand corner of the worksheet. This form is protected to prevent the changing of formulas and formatting features built into the spreadsheets. You may submit completed forms in an electronic format or printed format. You must ensure that the individual's information is protected as required by State and Federal law.

FOR ELECTRONIC FORMATS ONLY

If you submit this form to the Regional Center as an email attachment or on a CD ROM, use the following naming standard: Each file must start with the designated "F" followed by the provider's three-digit numerical designation and month and year. See chart for month designations. For example, F372-JA26 would reflect the DS 1968 form for provider ID# 372 for January 2026.

FORM USAGE

This form is to be used by Regional Centers when referring individuals to the Department of Rehabilitation (DOR) for Vocational Rehabilitation (VR) services.

Estimated Start Date: Enter the date the individual is estimated to start Vocational Rehabilitation (VR) services. Enter the date as DD/MM/YYYY.

FOR ELECTRONIC FORMATS ONLY: This form contains information protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). ***The file must be password protected*** to ensure the safety of the consumer's information. Coordinate with the Regional Center regarding protecting the consumer information contained in this form.

PROVIDER INSTRUCTIONS:*Individual Information*

- **Unique Client Identifier (UCI) Number:** Enter the individual's UCI number.
- **Last Name:** Enter the individual's last name.
- **First Name:** Enter the individual's first name.
- **Individual Email:** Enter the individual's email address.
- **Mailing Address/ City/ Zip Code:** Enter the individual's address, city, and zip code.
- **Phone:** Enter the telephone number where the individual can be contacted. Enter the telephone number as (###) ###-####.
- **Conservator/ Parent Last Name:** Enter the "Parent", "Conservator", or designated representative's last name.
- **First Name:** Enter the "Parent", "Conservator", or designated representative's first name.
- **Phone:** Enter the telephone number where the "Parent", "Conservator", or designated representative can be contacted. Enter the telephone number as (###) ###-####.
- **Mailing Address/ City/ Zip Code:** Enter the "Parent", "Conservator", or designated representative's address, city, and zip code.
- **Current Program:** Enter the name of the individual's current program.
- **Prior Program:** Enter the name of the prior program the individual was utilizing.

Individual Referral Choice

- **VR Referral (Clickable Box):** Click the box to place a checkmark, indicating whether the individual has been referred to Vocational Rehabilitation (VR) services.
- **Preferred Provider Name:** Enter the individual's preferred provider's name (leave blank if the individual has no choice of provider).
- **Office VR Counselor Name:** Enter the name of the individual's assigned VR counselor.
- **Office VR Counselor Email:** Enter the email address of the individual's assigned VR counselor.
- **VR Services (Clickable Boxes):** Click the applicable box to place a checkmark, indicating whether the individual will participate in a SEP – IP (Individual Placement), PIP or SIP (Paid Internship Program or State Internship Program, CES (Customized Employment Services) or has no Preference (at this time).
- **Reports (Clickable Box):** In the “Required” section, click the applicable box(es) to place a checkmark next to each report that is attached. The selected boxes indicate which required reports are included with the DS 1968 referral form.
 - CDER (Client Development Evaluation Report)
 - IPP (Individual Program Plan)
 - MED (Medical)
 - PSY (Psychological)
 - SOC (Social History)

NOTE: If required documents do not accompany the DS 1968 referral form, the individual's services may be delayed. Additionally, this form cannot be forwarded electronically based on the requirement to attach a copy of the report.

CERTIFICATION & AUTHORIZATION INSTRUCTIONS (TOP BOX)

Read the certification statement located in the “Certification” box prior to signing this section.

- **RC Name:** Enter the abbreviation of the Regional Center Name this is authorizing extended services for the individual:
 - **ACRC** (Alta California Regional Center)
 - **CVRC** (Central Valley Regional Center)
 - **ELARC** (East Los Angeles Regional Cener)
 - **FNRC** (Far Northern Regional Center)
 - **FDLRC** (Frank D. Lanterman Regional Center)
 - **GGRC** (Golden Gate Regional Center)
 - **HRC** (Harbor Regional Center)
 - **IRC** (Inland Regional Center)
 - **KRC** (Kern Regional Center)
 - **NBRC** (North Bay Regional Center)
 - **NLACRC** (North Los Angeles County Regional Center)
 - **RCRC** (Redwood Coast Regional Center)
 - **Regional Center**
 - **RCEB** (Regional Center of East Bay)
 - **RCOC** (Regional Center of Orange County)
 - **SARC** (San Andreas Regional Center)
 - **SDRC** (San Diego Regional Center)
 - **SG/ PRC** (San Gabriel/ Pomona Regional Center)
 - **SCLACRC** (South Central Los Angeles County Regional Center)
 - **TCRC** (Tri Counties Regional Center)
 - **VMRC** (Valley Mountain Regional Center)
 - **WRC** (Westside Regional Center)

- **RC Representative (PRINT):** Enter the RC Representative's first and last name.
- **RC Representative (SIGN):** Enter the RC Representative's signature.
- **Date:** Enter the date the RC Representative's signed the certification.
- **Phone Number:** Enter the RC Representative's telephone number.
- **Fax Number:** Enter the RC Representative's facsimile number. Enter facsimile number as (###) ####-####.
- **Email Address:** Enter the RC Representative's email address.

CERTIFICATION & AUTHORIZATION INSTRUCTIONS (BOTTOM BOX)

Read the consent statement located in the “Certification” box. By signing, you acknowledge that in the course of providing employment services, the information will be shared with the Department of Rehabilitation (DOR).

- **Individual's Signature:** The individual signs to indicate understanding and consent to the referral.
- **Conservator's Signature:** If applicable, the conservator signs on behalf of the individual.
- **Date:** Enter the date the signature is provided.
- **Witness Name (If Required):** Enter the witness's name, if required.
- **Witness Name (If Required):** *The witness signs, if required.*
- **Date:** Enter the date the witness signs.

NOTICE: Read the notice and use the information to safeguard the consumer's information in accordance with the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164).

FORM DISTRIBUTION INSTRUCTIONS

When the referral is for Vocational Rehabilitation (VR), distribute copies of the completed form as follows.

- **Original:** The original form and all attachments to be sent to the VR office.
- **Copy 1:** One copy to be filed for the Regional Center's records.
- **Copy 2:** One copy to be provided to the VR Service Provider.
- **Copy 3:** One copy to be provided to the individual and their records.

FUNCTIONAL LIMITATIONS AND SUPPORT NEEDS INSTRUCTIONS

Review each of the functional areas listed under the “Category” column. For each category, click one box under “Level of Limitation” to place a checkmark indicating the individual's current level of need. Use the “Notes” section to provide brief examples, context, or supports required (e.g., accommodations, job coaching strategies, assistive devices).

RATING SCALE:

- **None:** No observable limitation; functions independently.
- **Mild:** Occasional difficulty; may require minimal prompting or support.
- **Moderate:** Ongoing difficulty; requires regular support or accommodation.
- **Severe:** Significant difficulty; requires consistent or intensive support.

Regional Center ID #:

Code	ABBRV	RC NAME
360	FDLRC	Frank D. Lanterman Regional Center
361	GGRC	Golden Gate Regional Center
362	SDRC	San Diego Regional Center
363	FNRC	Far Northern Regional Center
364	ACRC	Alta California Regional Center
365	SARC	San Andreas Regional Center
366	TCRC	Tri-Counties Regional Center
367	CVRC	Central Valley Regional Center
368	RCOC	Regional Center of Orange County
369	IRC	Inland Regional Center
370	RCRC	Redwood Coast Regional Center
371	NBRC	North Bay Regional Center
372	KRC	Kern Regional Center
373	ELARC	East Los Angeles Regional Center
374	SCLARC	South Central Los Angeles Regional Center
375	HRC	Harbor Regional Center
376	WRC	Westside Regional Center
377	VMRC	Valley Mountain Regional Center
378	NLACRC	North Los Angeles County Regional Center
379	SGPRC	San Gabriel/Pomona Regional Center
380	RCEB	Regional Center of the East Bay

DOR Vocational Rehabilitation (VR) ID #:

2218	VR	DOR Vocational Rehabilitation
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Month Designations:

January	JA	April	AP	July	JL	October	OC
February	FE	May	MY	August	AG	November	NO
March	MR	June	JN	September	SE	December	DE