Office Use **Approved:** **Denied:** **Reason:**

Referred To:

Approval Email Received:

Request for Services

Please email completed Request for Services to Jennifer.M.Thoren@mass.gov
A brief email approving the request from the Area Director or AAD is required to process the request.* Please email approval to: Jennifer.M.Thoren@mass.gov
* Not applicable for Orientation & Mobility request**.**

Date of Referral:	
Name:	
Address:	Contact Person: Phone: Email:
Service Coordinator:	
Phone:	Area Office:
Day/Work Agency:	
Address:	Contact Person: Phone: Email:

☐ Vocational ☐ Supported Employment

☐ Day Hab ☐ Other:

Type of Service Requested:

☐ PT Eval

☐ OT Eval

☐ Adaptive Design (ATRC)

☐ APE*

*** Please include the Medical Clearance & the Health Review for Participation in an Exercise Program forms. Both forms must be signed and dated within 45 days of this request).**

☐ O&M/Low Vision Assessment **

**** Please mail or fax copies of the most recent eye reports to:**
Lisa DiBonaventura, P.O. Box 144, Wrentham, MA 02093
Fax: (508) 384-6771

Reason for Referral:	
Identifying Data	
Date of Birth:	Language Spoken:
Diagnosis:	Psychiatric Diagnosis:
Functioning Level:	
What community resources have been explored? Please include dates of service and why service was not provided.	
Medical Health Issues:	Mental Health Issues:
Other Relevant Information:	

For O&M Referrals: Eye Doctor Information	
Name:	Phone:
Address:	
☐ Optometrist ☐ Ophthalmologist	

Lens Crafters Gift of Sight Charitable Program Request	
Contact Person:	Phone:
Mailing Address:	
Mailing Address of Lens Crafters Store:	Phone:
Date of Prescription:	
Please describe other sources of payment that have been explored.	