RochesterWorks
A proud partner of the americanjobcenter network

One-Stop System Referral Instructions

1. Fill in the Referral Information section as completely as you can.
   - Data entry boxes will expand as you type.
   - Any box that contains, "Choose an item" is a drop-down box. You must click in the box, and then select an entry.
   - The NY # field is for the OSOS ID. If your program does not use OSOS, you may leave this field blank.

Referral Information

Date of Referral: 7/6/2018
NY #: NY01234567
Customer Name: Paula Participant **Gender:** Female **DOB (m/d/yyyy):** 6/10/1980
Address: 123 Main St. **City:** Rochester **State:** NY **Zip Code:** 14600
Telephone: 585-867-5309 **Alternate Telephone:** 585-555-1212 **Email Address:** pparticipant@noemail.com
Transportation: Public/bus **Highest Level of Education Completed:** HS Diploma/GED/HSE
Job Status: Unemployed **Level of Computer Proficiency:** Intermediate
Are you a person with a disability? No **Are you a veteran?** No
Are you a U.S. Citizen? Yes **If not, are you authorized to work in the United States?** Choose an item
Have you resided in NY State for at least the past 12 months? Yes
Are you or a member of your family receiving public assistance? Yes
If you answered yes, please indicate the type of public assistance you are receiving. Cash Assistance
Annual Income: $4,800 **Source:** Child Support **Family Size:** 3

2. Fill in the second box, including purpose of the referral and supportive services needed. Be specific.

Purpose of the referral: Paula is on probation and needs assistance overcoming barriers to employment. She does not have her RAP Sheet or a Certificate of Rehabilitation.

Supportive services needed: Legal assistance, obtaining RAP Sheet and a Certificate of Relief From Disabilities

3. Fill in the Referral Agency(ies) box. You may check more than one partner, if applicable. If not sure where to refer, check out the directory at https://rochesterworks.org/our-partners/.

Partner Making the Referral

Representative Name: Carl Counselor **Phone:** 585-258-3500 **Email:** ccounselor@rochesterworks.org
Agency: RochesterWorks! Career Center ☒ *Assessment available* ☒ *We will continue to provide services*

Referring to the following agencies (include agency phone numbers in space provided below):

- ☐ ACCES-VR
- ☐ Action for a Better Community
- ☐ Adult Education*
- ☐ Job Corps
- ☐ Monroe County Department of Human Services
- ☐ Native American Culture Center
- ☐ NYS Commission for the Blind (NYSCB)
- ☐ PathStone
- ☐ Perkins Career and Technical Education*
- ☐ Rochester Housing Authority
- ☐ RochesterWorks!/New York State Department of Labor (Adult/DW)
- ☐ Senior Community Service Employment Programs*
- ☐ WIOA Youth*
- ☐ YouthBuild*
- ☒ Other Community Partners Other Reentry Employment Opportunities program

4. Print out the form. Then review the Permission to Release Information on page 2. Both the participant and referring staff member should sign and date the release.

Permission to Release Information

By signing this document, I understand that I am authorizing the WIOA Partner Staff to release this document and/or other information to other government, public, or private organizations or agencies that may have the ability to assist me with services.
By signing this document, the customer acknowledges that they understand that:

- All such information will be treated as confidential and privileged;
- The information will be used only for the purpose of obtaining services offered through the One-Stop System;
- I can withdraw permission to release or obtain information by writing to RochesterWorks, Inc. (this will not affect actions already taken with my permission).

_____ _____
Participant Signature/Legal Guardian (if applicable) Date (m/d/yyyy)

_____ _____
Agency Signature/Agency Date (m/d/yyyy)

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5. Forward both pages to the receiving agency. Be sure to comply with your organization's policy on protecting participant information. For a directory of partner agency liaisons, including contact information, see https://rochesterworks.org/our-partners/.

6. **For the Receiving Agency:** Complete the Results of Referral box on p. 2, and forward the referral to the designated individual within your agency. *Within ___ days, return the referral form to the partner who made the referral, with the results section completed.*

Results of Referral (TO BE COMPLETED BY RECEIVING AGENCY)

○ Customer Served	○ Service Refused
○ Unable to Contact	○ Failed to Appear
○ Other (explain):	○ ***Co-Enrolled***

Completed By (Signature): _____ Date: _____

Notes: