Vocational Services
Referral Form / Vocational Screening Assessment

Identify location: □ 1925 Greenspring Drive Timonium, MD 21093 □ 2225 N. Charles Street Baltimore, MD 21218 □ 288 E. Green Street Westminster, MD. 21157

Please complete the form entirely and attach supporting documentation related to mental health status, guardianship, work history, etc.

Client Name: _____ Social Security #: _____
First Middle Initial Last
Address: _____ _____

Date of Birth: _____ Phone #: _____

Does individual attend a Mosaic Day Program? _____ If yes, what days? _____

New Ventures/Winters Lane/Granite Hall/North Charles/Wharf Point/Rosedale (please circle one)

Race (Please indicate all that apply):
Caucasian
African American
Asian
Native Hawaiian or Pacific Islander
Native American
Hispanic
Other: _____
Prefer not to disclose

Gender Identity:
Male
Female
Transgender
Other: _____
Prefer not to disclose

Does individual have guardian of person or property? Yes/No
(If so, please attach documentation verifying guardianship)
Has Guardian been notified of this referral? Yes/No

Does the individual meet priority population criteria? Yes/No

Services Requesting: O 1. Supported Employment O 2. Other/ Specify: _____
Employment Status: O Employed O Unemployed O Volunteer

Benefits: O SSI: _____ O SSDI: _____ O M. A. #: _____ O Private Insurance? Yes / No

Primary DSM 5/ Mental Health Diagnosis:_____ Code:_____
Additional Diagnosis: _____ Code: _____
Additional Diagnosis: _____ Code: _____
Medical Diagnosis: _____ Code: _____

Therapist: _____ Phone #: _____
Agency/Address: _____

Psychiatrist: _____ Phone #: _____
Agency/Address: _____

Rehabilitation Counselor: _____ Phone #: _____
Service Coordinator: _____ Phone #: _____
DORS Counselor: _____ Phone #: _____

Employment Goal:_____

Is the individual interested in competitive employment and have a desire to work in the community? Yes/No

Is the individual willing to participate in Supported Employment services? Yes / No

Does the individual need ongoing help to choose, obtain, maintain, or advance in employment? Yes / No

If the individual is employed, do they need help maintaining their job? Yes/No

If the individual does not have an open case with DORS, is he/she willing to be referred? Yes / No

Any known risk taking behavior? (i.e. recent suicide attempt, etc.) _____

List any special accommodations needed: _____

***In the unfortunate event that a waiting list exists, both the referred individual and the referral source will be immediately notified of the approximate wait time and alternative resources. Both will continue to be updated every two weeks until the individual has been contacted by the intake or program coordinator for an intake.**

Referred By: _____
Name/Title/Program Phone Number

Referral's Signature: _____ Date: _____

Please fax the completed referral and supporting documentation to (443) 612-1400, or email referrals@mosaicinc.org.

Office Use Only: Date Received: _____
Screening Reviewed By: _____
Signature/Title

Assigned Employment Specialist: _____

Dev: 7/06 Rev: 7/06, 1/09, 2/10, 5/10, 8/10, 12/12, 11/15; 7/16; 1/17