**CUSTOMER INFORMATION** ❑ **Customer is Guardian Overall VIP\_\_\_\_\_ Business Incubator\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Customer Name (Last, First, Middle Initial) | | Date |
| Address/P.O. Box | Date of Birth | Sex (circle) M F |
| City, State, Zip Code | Ethnicity | Social Security Number |
| Email Address | Primary Telephone | |
| Guardian Name: | Guardian’s Telephone | |

**VR COUNSELOR INFORMATION ❑ Referral**

|  |  |  |  |
| --- | --- | --- | --- |
| Counselor’s Name | Office Telephone | | FAX |
| Office Name | Customer’s VR Number: | | |
| Office Address | Email Address | | |
| City, State, Zip Code | Customer has current IPE  ❑ Yes ❑ No | District Number: | |

**SSI/SSDI**

|  |  |
| --- | --- |
| ❑ Customer Receives S.S.I ❑ SSDI | ❑ Customer is NOT S.S.I. Payee. ❑ SSDI |
| Name of Payee: | Address of Payee: |

**SCHOOL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Name of High School | Did you graduate? Date:  ❑ Yes ❑ No | GED: Date:  ❑ Yes ❑ No |
| Address | School Telephone: | School Fax: |
| City | State | ZIP |
| Did you have an IEP or Section 504 Plan?  ❑ Yes ❑ No | | |

**COLLEGE/TRAINING SCHOOL INFORMATION ❑ N/A**

|  |  |  |
| --- | --- | --- |
| Name of School | Did you graduate?  ❑ Yes ❑ No | If no, credit hours completed: |
| Address | School Telephone: | School Fax: |
| City | State | ZIP |
| Major | Minor ❑ N/A | |

**SPECIALIZED TRAINING ❑ N/A**

|  |  |  |
| --- | --- | --- |
| Name of School | Certificate Received? ❑ Yes ❑ No Type: | |
| Address | Telephone: | Fax: |
| City | State | ZIP |
| Type of Training: | Certificate? |  |

|  |  |  |
| --- | --- | --- |
| Name | Relationship to Customer: | |
| Address | Telephone: | Cell: |
| City, State, Zip Code | Fax Number: | Secondary Cell: |
| Email Address: | Secondary Email Address: | |

**EMERGENCY CONTACT INFORMATION**

**PRIMARY HEALTH CARE PROVIDER / INSURANCE INFORMATION**

|  |  |  |
| --- | --- | --- |
| Name | Email Address: | |
| Office Name | Telephone Number: | Fax Number: |
| Medical Insurance ❑ N/A | Insurance Company Name: | |
| ❑ Medicaid or ❑ Medicare | Recipient Number: | |

**MEDICATIONS AND TREATMENTS**

|  |  |
| --- | --- |
| Primary Diagnosis | Date of Diagnosis of Disability |
| Secondary Diagnosis (medical conditions) | Do you require any accommodations? |
| Vision: Does Customer wear glasses?  ❑ Yes ❑ No | Hearing: Does Customer wear aids?  ❑ Yes ❑ No |
| Allergies ❑ Yes ❑ No  List: | Seizures: ❑ Yes ❑ No |
| Please list all medications and medical treatments the customer is currently receiving | |
| **Name** | **Dosage / Frequency/ Doctor** |
|  |  |
|  |  |
|  |  |
|  |  |

If I am accepted into the VIP of Chicago, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will comply with all DHS, DRS, and VIP policies, procedures, guidelines, rules, and regulations.

Print Name of signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_