**Vocational/Business Incubator Application**

 **\_\_\_\_\_ Business Intensive\_\_\_\_\_ Vocational Training Courses\_\_\_\_\_ Business Incubator**

**VR Customer Information**

|  |  |
| --- | --- |
| Customer Name (First, Middle Initial, Last Name) | Date |
| Address/P.O. Box | Date of Birth | Sex (circle) M F |
| City, State, Zip Code | Ethnicity | Social Security Number |
| Email Address | Customer’s Telephone |
| Allergies: Yes, No | Primary Diagnosis: |
| **Guardian’s Name (guardianship documentation required)** | Guardian/Parent telephone: |
| Attendants Name | Attendants telephone: |

**VR COUNSELOR INFORMATION ❑ Referral** **❑ Release** **❑ IPE**

|  |  |  |
| --- | --- | --- |
| 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: |

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

|  |  |  |
| --- | --- | --- |
| **Primary - Name/ Relationship** | **Telephone** | **Telephone** |
| **Address** | **City, State, Zip Code** |
| **Email Address** | **Back up /Email address** |
| **Secondary - Name/Relationship** | **Telephone** | **Telephone** |
| **Address** | **City, State, Zip Code** |

**Customer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Information**

**Primary Health Care Provider**

|  |  |
| --- | --- |
| Primary Health Care Provider/ Doctor | Office Name |
| Office Name | Telephone: | Fax Number |
| Address | City, State, Zip Code |
| Email Address: | Secondary Email Address: |

 **Insurance Information**

|  |  |
| --- | --- |
| 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 ❑ NoList:  | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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