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| **All Information Below is Optional but Helpful for Application** | |
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| ***Education Information to be completed by person making referral*** | |
| Referral will be facilitated by including **one** **or more** of the following:  Current IEP and most recent psychological report  Current 504 Plan and supporting documents  Current Physician Report with diagnosis  Other Relevant Information | |
| Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CSE Classification, 504 or Medical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Grade Most Recently Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected Year of School Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type of Degree/Certificate Anticipated:  Regents  Local  CDOS  Skills & Achievement  School District Student Resides In: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School Student Attends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Name of person making referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Can Choose to Complete Following with ACCES-VR Counselor at First Meeting*** |
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| ***Health, Residence & Work Questionnaire: To Be Completed By Student And Parent/Guardian*** |
| Do you have or have you ever had any of the following conditions?  ADHD  Depression  Intellectual Disability  Seizure Disorder  Allergies/Asthma  Diabetes  Kidney Disease  Skin Disease/Rash  Anxiety  Drug/Alcohol Abuse  Learning Disability  Speech/Language Disorder  Arthritis  Head Injury  Mental Illness  Stroke  Autism Spectrum  Hearing Loss  Muscular Dystrophy  Ulcers/Colitis/Crohn’s Disease  Cancer  Heart Disease  Orthopedic Limitations  Vision (not corrected by glasses)  Cerebral Palsy  HIV Related Diseases  Respiratory Disorder  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List of Medications:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Medical Insurance at Application:***  Medicaid  Medicare  Other Private  Private Through Employment  Workers Compensation  None  ***Living Arrangements at Application:***  Private Residence  Foster Care  Homeless  Community Residence  Halfway House  Substance Abuse Treatment Facility  Mental Health Facility  Correctional Facility  Other  ***Work Status at Application:***  Employed with a job coach  Employed on my own  Not presently employed |