IPS Application

Application Date: _____

Referral Source Contact: (Name, Phone, Email): _____
_____

Applicant Information

_____
First Name **Middle Name** **Last Name**

Address (Street, City, State, Zip): _____

_____

Primary Phone # (_____)_____

Social Security #:_____

Date of Birth: _____ **Age:** _____ **Male____ Female____**

Marital Status: **Single_____** **Married_____** **Divorced_____**

Emergency Contact- (Name and Phone #): _____

_____

Is the person homeless? **___ Yes ___ No**
Does the person have a legal guardian? (send proof if applicable) **___ Yes ___ No**
Does the person have a case manager or care coordinator? **___ Yes ___ No**
Does the person have a Vocational Rehabilitation counselor? **___ Yes ___ No**
Is the person on probation? **___ Yes ___ No**
Is the person on the Sexual Offender Registry? **___ Yes ___ No**
List any founded and or pending criminal charges: _____
_____
_____

Medical Information

Primary Disability: _____

Other Disabilities: _____

Is there a history of seizures? ____ Yes ____ No
Is the person diabetic? ____ Yes ____ No
If yes, can they self-administer the insulin? ____ Yes ____ No
Allergies- please list _____

Please list current medications (or attach a med list):
_____

_____

Support Team Information			
Type of Support	**Name**	**Town**	**Contact #**
Guardian			
Case Manager/IHH			
Voc Rehab Counselor			
Family Member			
Psychiatrist			
Therapist			
Other			

Thank you for your interest. Please submit completed applications to IPS@firstresources.us.