

IPS – IVRS 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	
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
Allergies- please 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.