TRANSITION PROGRAMS APPLICATION

For Office Use Only: Date Received _____

Student Information:			
Student Name:		**DOB:**	
Student Address:		**Date of student's 22nd birthday?**	
Street:		**Social Security #:**	
City:		**Student Cell Number:**	
State, Zip Code:		**Student Email:**	
Student School ID#		**School District:**	
Primary Disability:	**Related Service:**		
Shirt Size:		**IEP Case Manager:**	
Number of absences this year:		**Email Address:**	

Parent/Guardian Information	
Father:	**Home Phone:**
Address:	**Cell Phone:**
Father's Place of Employment:	**Work Phone:**
	Email Address:
Mother:	**Home Phone:**
Address:	**Cell Phone:**
Mother's Place of Employment	**Work Phone:**
	Email Address:

Legal Guardian Information		
Is the student his or her own guardian: *****If no, please attach court documents.**	**YES**	**NO**

Educational Needs and Goals:		
Student's High School:		
Will the student have all credits necessary to meet graduation requirements at the end of his academic year?	**YES**	**NO**
Has the student ever been placed on a behavioral plan while in high school? **If yes, please attach to the application with any supporting documentation.**	**YES**	**NO**
Has the student ever been suspended/excluded/removed from high school? **If yes, please describe:**	**YES**	**NO**
Has the student been involved in the court system: **If yes, please describe:**	**YES**	**NO**
Other than public education, has the student received any additional formal training? (Bridges, Goodwill, etc.) **If yes, list date and location of any additional formal training:**	**YES**	**NO**

Employment Needs and Goals:					
What are the student's employment goals?				**Competitive Employment**	**Supported Employment**
Does the student want to work full-time or part-time?				**Full-Time (40hrs/week)**	**Part-Time (20hrs/week)**
Does the student plan to work during the school year **If Yes, where?** **How many hours per week?**				**YES**	**NO**
Will the student work over the summer break? **If yes where?** **If yes, how many hours a week?**				**YES**	**NO**
Does the student have previous paid work experience <u>OUTSIDE</u> of the school programming? If YES, provide the details requested below:				**YES**	**NO**
Employer	**Job Title**	**Hours/Week**	**Supervisor**	**Phone #**	**Dates of Employment**

Did the student receive job coaching or other support in previous jobs?	**YES**	**NO**
How many hours per week?		
If yes, what type?		
Did the student receive any disability accommodations in previous Jobs? **If so, what type?**	**YES**	**NO**
Has the student obtained any previous jobs without assistance?	**YES**	**NO**
Has the student ever been fired from a job? **If yes, why?**	**YES**	**NO**
Has the student ever quit a job? **If yes, why?**	**YES**	**NO**
List any student disability accommodations requested for training purposes:		

School Work – Study Experiences					
Organization	Volunteer Duties	Hours/Week	Supervisor	Phone #	Dates of Service

Other Work Experiences					
Does the student have previous volunteer experience? If yes, provide details requested below:				YES	NO
Organization	Volunteer Duties	Hours/Week	Supervisor	Phone #	Dates of Service

Support Services				
Is the student eligible for services from Tennessee Vocational Rehabilitation Services?			YES	NO
If YES, list the Tennessee Vocational Rehabilitation Services Counselor's name and phone number:			Name	Phone #
Is the student SSI or SSDI eligible? If yes, please attach the award letter.			YES	NO
Is the student eligible for services from the Department of Intellectual & Developmental Disabilities (DIDD)?			YES	NO
If Yes, list the DIDD service support coordinator's name and phone number.			Name	Phone#
If NO, is the student interested in applying for DIDD Eligibility?			YES	NO
Has the student utilized services from other agencies in the past? If yes, provide the details requested below: (mental health, etc.)			YES	NO
Agency	Services Provided	Agency Contact	Phone #	Dates of Service

Living Arrangements and Daily Care		
Who does the student live with?		
Does the student set and use an alarm clock independently?	YES	NO
Does the student get up in the morning on his/her own? If no, how does he/she wake up?	YES	NO
Does the student perform daily care on his/her own? (Bathing, grooming, dressing, etc.?)		

Please Circle One:			
No Assistance	*Minimal Assistance*	*Occasional Assistance*	*Total Assistance*

If assistance is needed, who assists the student?

Medical History

Please list student's medical and psychological diagnosis:

Has the student ever received any counseling or therapy?	**YES**	**NO**
If yes, please list the name and number of the counselor and or therapist.	**Name**	**Phone #**

Please list any hospitalization and or surgeries that the student has had:

Date	Hospital	Reason

Does the student have allergies? **If yes, what? (Medical, seasonal, or food? Please describe severity.)**	**YES**	**NO**

Please list kinds of aid/supports or assistive technology that the student uses to accommodate a physical disability:

Does the student take medication on a regular basis? **If yes, provide the details requested below:**				**YES**	**NO**
Medication	**Purpose**	**Dosage Amount**	**Dosage Schedule**	**Prescribing Physician**	**Physician Phone #**

Does the student have an Emergency Plan? (seizure plan, etc) **If yes, please attach.**	**YES**	**NO**
Does the student wear glasses or contacts? **If yes, please explain the nature of his/her vision impairment:**	**YES**	**NO**

Does the student use any devices or aids to assist with his/her hearing? If yes, please explain the nature of his/her hearing impairment:	**YES**	**NO**
Does the student use sign language or any other nontraditional form of communication:	**YES**	**NO**
Do parents/guardians/family members use sign language or any other nontraditional form of communication?	**YES**	**NO**
Future Planning		
Does the student currently hold a driver's license?	**YES**	**NO**
Does the student currently have driving permit?	**YES**	**NO**
Does the student have plans to take the driver's test?	**YES**	**NO**
Will the student obtain a driver's license within the next year?	**YES**	**NO**
Will a family member provide the student with transportation to the workplace/training site? If yes, who?	**YES**	**NO**
Can the student travel to the workplace using public transportation?	**YES**	**NO**

Disability Awareness
In the student's words, please describe his/her disability and the effect it has on daily activities at school, home and in the community. (A scribe can be used if appropriate)

Please list the names and roles of the IEP team members that completed this application:

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I agree to the release of all pertinent school and medical records to Shelby County Schools Transition Programs Screening Committee.

Student Signature_____ **Date**_____

Parent Signature_____ **Date**_____

Legal Guardian Signature_____ **Date**_____