**\*\*THE TRC APPLICATION *MUST* BE COMPLETED IN ITS ENTIRETY TO BE CONSIDERED FOR THE “PRE-EMPLOYMENT TRANSITION SERVICES PILOT PROGRAMS”\*\***

Department of Human Services **TENNESSEE REHABILITATION CENTER** TRC-A1

Division of Rehabilitation Services **APPLICATION FOR SERVICES**

Applicant's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First Middle (Maiden)

Address:

Street City County Zip

Telephone #: Alternate Telephone #:

Email Address: Date of Birth: / / SEX: M  F

Social Security # / /

Are you currently enrolled in school?  Yes  No What grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where are you enrolled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RACE:  White  Black or African American  Asian  American Indian or Alaskan Native

Native Hawaiian or Other Pacific Islander ETHNIC:  Hispanic or Latino

**MEDICAL CARE AND SEARCH AND INSPECTION**

I hereby give permission to the Tennessee Rehabilitation Center, to include physicians, nurses, assistants, and others whom they may call to their aide, to administer any emergency treatment, medication, or procedure upon me as they, in their judgment, may deem advisable in the care and treatment of my case; and that, in an emergency situation, I may be transported to an emergency medical facility to receive treatment and care. If I require any medical services, my medical insurance or TennCare card will be billed for services to be paid by my insurance. I understand that I am responsible for all fees and costs associated with medical care. **\*\*\*\*Please attach a copy of current medical insurance card\*\*\*\***

I acknowledge and understand that Center officials have the right to enter into facility-owned property or student property brought to the facility for the purpose of search and seizure if there is a reasonable cause to believe that a student is using property for purposes which are illegal or contrary to the regulations of the facility.

**EMERGENCY CONTACT INFORMATION**

I understand and agree that in the case of an emergency the individual listed below will be contacted.

NAME (please print name of emergency contact):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If agency, please designate name of agency.

ADDRESS: HOME PHONE # ( )

Street/Apartment #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip CELL PHONE # (\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO APPLICANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If agency, please designate signatory authority on behalf of agency.)

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please select the program you wish to attend:**

**Traumatic Brain Injury (TBI) Evaluation and Transitional Education Program Pilot –** Dates of sessions will be individualized and scheduled as applications approved

**“Ready Set Go!” Pilot** - Dates of sessions will be 6/17, 6/20, 6/22, 6/24, 6/27, and 6/29. Daily sessions will begin at 9:00 am and end at 2:30 pm.

**TRC Workplace Social Skills Training Boot Camp for Autism Spectrum Disorder (ASD) Pilot -** Dates of sessions will be 6/28, 7/12, 7/19, and 7/26. Daily sessions will begin at 9:00 am and end at 2:30 pm

**Comprehensive Vocational Evaluation with Career and Post-Secondary Education Experience –** Dates of sessions will be6/28/16 – 7/1/16; 7/11/16 – 7/15/16; and 7/18/16 – 7/22/16. Daily sessions will begin at 9:00 am and end at 2:30 pm.

Do you have a Vocational Rehabilitation Counselor?  Yes  No

If yes, please provide name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Disabilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Applicant's Signature

Signature of Parent, Guardian (if under 18), or Conservator:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Parent/Guardian/Conservator

Does applicant have a court appointed guardian or conservator?  Yes  No If yes, please attach legal order/verification.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. To file a complaint of discrimination, complete the Program Discrimination Complaint Form, found online at <https://wdcrobcolp01.ed.gov/CFAPPS/OCR/contactus.cfm> or you may write Tennessee, Department of Human Services, Office of General Counsel, Compliance Officer, Citizens Plaza Building, 400 Deaderick Street, Nashville, TN 37243, (615) 313-4700.