State of Illinois
Department of Human Services - Division of Rehabilitation Services - Community Resources

FAST TRACK TRANSITION SERVICES INTAKE

Personal Information			
Name:	(Last, First, Middle):		
Home Address:	Street:		
	City:		
	State:		
	Zip Code:		
Parent or Legal Guardian:	☐ Yes ☐ No	Parent/Legal Guardian Name:	
Contact Information:	Home Phone:	Cell Phone:	E-mail Address:
Birth Date:		Social Security Number:	
Referring Agency:			
Gender:	☐ Male ☐ Female ☐ Not Reporting		
Ethnicity:	☐ Black ☐ White ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander		
Preferred Language:			
Disabilities:			

Education Information			
Are you currently enrolled in school?		☐ Yes ☐ No	
Name of School currently attending			
Highest Grade Level Completed:	Enrolled in High School: (Check current year level) Expected Graduation:	☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 12+ Date	
	Certification of Completion	Date	
	High School Diploma or GED:	Date	
	Post-Secondary Education (no degree or certificate)	Number of Credit Hours:	
Education and Support Services:	☐ IEP ☐ 504 ☐ None ☐ Other: If other (list):		

I am a student over the age of 18 or a parent who consents to participation in Fast Track Transition.

Student, Parent/Legal Guardian Printed Name and Signature Date

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FAST TRACK TRANSITION SERVICES AGREEMENT

Customer Name:	
Case Number:	Date:

Qualification for Services

The Illinois Division of Rehabilitation Services (DRS) confirms the student meets the following criteria necessary to qualify for Pre-employment Transition Services (PTS) in the Fast Track Transition program. The student:

- ☐ Is at least 14 years old but less than age 22;
- ☐ Has a disability documented with an IEP, 504 Plan, medical records or documentation from a physician;
- ☐ Is enrolled in a secondary school (including home school or other alternative secondary education program,) post-secondary education program, or another recognized educational program and has not exited, graduated, or withdrawn.

The Vocational Rehabilitation Counselor verifies that this is a qualified student with a disability and approves the services in this agreement.

Counselor Printed Name and Signature:	Date:

Services

Because the individual meets the definition of a "student with a disability" for purposes of IDEA or 504, the customer is qualified to receive PTS. It is anticipated that the student will participate in services indicated including:

☐ Job Exploration Counseling		
Chosen Provider:		
Dates of Service:	From:	To:

☐ Work-Based Learning Experience		
Chosen Provider:		
Dates of Service:	From:	To:

☐ Work Place Readiness Training		
Chosen Provider:		
Dates of Service:	From:	To:

☐ Counseling on Opportunities for Enrollment in Comprehensive Transition or Post-Secondary Education Programs at Institutions of Higher Education		
Chosen Provider:		
Dates of Service:	From:	To:

☐ Instruction in Self- Advocacy		
Chosen Provider:		
Dates of Service:	From:	To:

I agree to participate in PTS and understand services are limited to those listed above. Participation in PTS does not certify me for services provided in the vocational rehabilitation program. I understand to participate in vocational rehabilitation services, I will need to apply and be determined eligible.

Student Printed Name and Signature:	Date:
Parent/Legal Guardian Printed Name and Signature:	Date: