State of Illinois
Department of Human Services

# MEDIA CONSENT AND RELEASE FORM

I hereby consent and authorize the Illinois Department of Human Services (Department) and those acting pursuant to its authority, including its employees, agents, officers, contractors and volunteers, to:

1) record my name, voice, likeness, image, interview and/or story on videotape, audiotape, photograph, digital, electronic or any other medium;

2) use my name and identity in connection with these recordings; and

3) use, reproduce, exhibit or distribute (including to the media) in any medium these recordings for the specific purpose of: _____ .

I understand the reproduction of any recordings may require alternations, additions or editing as deemed necessary by the Department. Also, I understand that my name, likeness, picture, recording and/or story will not be used for profit and that I will not be paid for use of same.

I agree that any uses described herein may be made without compensation or additional consideration to me in any form, including reimbursement for any expenses incurred by me. I understand that no promises or representations have been made to me other than those stated herein.

I now and forever waive any rights, claims or interests I may have to control the use of my name, voice, likeness, image, interview and/or story in the recording authorized above. I hereby release and hold harmless, the Department, and those acting pursuant to its authority, including its employees, agents, officers, contractors and volunteers from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of use of my name, voice, likeness, image, interview and/or story.

By my signature below, I agree that I am participating on a volunteer basis and I represent that I have read and fully understand the terms of this release.

Mail to: Office of Communications 401 S. Clinton, 7th Floor Chicago, Illinois 60607, or call (312) 793-2345
1-866-324-5553 TTY/Nextalk, 711 TTY Relay

| Name: (Please Print) | Telephone Number: |
|---|---|
| | |
| **Street:** | **E-Mail:** |
| | |

| City | State: | Zip Code: |
|---|---|---|
| | | |

| Signature: | Date: |
|---|---|
| | |

| If under 18, Print Name of Parent/Guardian: | Signature of Parent/Guardian: |
|---|---|
| | |

| Witness Printed Name and Signature: | Date: |
|---|---|
| | |

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

# STUDENT SERVICES REQUEST

| Student Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Mailing Address | City | Zip Code | County |
|---|---|---|---|
| | | | |

| Phone Number | Email Address |
|---|---|
| | |

| Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female ☐ Decline to State |
|---|---|
| | |

Race (please check all that apply)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander
☐ Chinese ☐ Korean ☐ Asian Indian ☐ Japanese ☐ Vietnamese
☐ Filipino ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Decline to State

Ethnicity:
Hispanic / Latino
☐ Yes ☐ No

Please state the student's disability or reason for IEP/504 eligibility:

Documentation (please select one)
☐ IEP (provide a copy)
☐ 504 Plan (provide a copy)
☐ School Signature (see below)
☐ Other (specify type and attach a copy if applicable

**Complete this section only if "School Signature" is selected:** I confirm that the student is enrolled in the school identified below and has a record of or is regarded as having the disability stated above.

Signature of School Official: _____ Time: _____

Printed Name of School Official: _____ Date: _____

| School Name | School Address | ☐ Secondary School<br>☐ Postsecondary School |
|---|---|---|
| | | |

School Type
☐ Public ☐ Private ☐ Charter ☐ Home School ☐ GED Program
☐ Vocational/Technical ☐ College/University ☐ Other

Expected Date of Graduation / Exit (mm/dd/yyyy)

| Parent/Guardian/Conservator Last Name | First Name | Relationship |
|---|---|---|
| Phone Number | Email Address | ☐ Parent<br>☐ Guardian<br>☐ Conservator |

I give permission to school personnel to release this information to the Department of Rehabilitation. (20 U.S.C. 1232g(b) and 34 CFR 99.30 and 99.31.) I confirm that the student has documentation of or is regarded as having the disability stated above. I give consent for the student to participate in student services provided or arranged by the DOR, for as long as the student qualifies for such services.

| Student Signature | Date Signed | Parent/Guardian/Conservator Signature | Date Signed |
|---|---|---|---|
| | | | |

# STUDENT SERVICES REQUEST

## Form Purpose

This form is intended to request student services for potentially eligible students, in accordance with 34 CFR 361.48(a). Student services may include any of the following pre-employment transition services: job exploration counseling, work-based learning experiences, postsecondary enrollment counseling, work readiness training, and self-advocacy training. "Potentially eligible" students are defined as students with disabilities, ages 16 through 21, who have not yet applied or been found eligible for the vocational rehabilitation program. This is not an application for vocational rehabilitation services. Please go to the online application to access an application for vocational rehabilitation services.

## Form Completion Instructions

Complete this form to document that the student is currently enrolled in a recognized education program and is considered a student with a disability as defined in 34 CFR 361.5(c)(51). Parent/Guardian contact information and consent are required for students with disabilities who are less than 18 years of age and not an emancipated minor.

## Notice and Privacy Statement

The information requested on this form is necessary to correctly identify the individual as a student with a disability as defined in 34 CFR 361.5(c)(51), to provide authorization for the provision of pre-employment transition services, and to provide authorization for school personnel to release the information requested on this form to the DHS-DRS to coordinate, provide, or arrange student services in accordance with 29 USC sections 705(37) and 733 and 34 CFR parts 361.48(a) and 361.5(c)(51). Individuals should not provide any personal information on this form that is not requested.

The DHS-DRS has an office locator. Select “Rehabilitation Services” and enter your county to find the office closest to you. The link is: https://www.dhs.state.il.us/page.aspx?module=12&officetype=7.

State of Illinois
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# Release of Information

I authorize the release of medical, financial, personal and other program information by

_____ agency, the fiscal/employer agent and by the Illinois Department of Human Services (DHS). This information may be released for the purposes of determining my eligibility for programs, planning my services and supports and monitoring my service delivery. The information may also be used to audit agencies providing my services and to review programs. Information may be released only if it is necessary to accomplish these purposes.

**This release is valid until** _____ **(Expiration Date).**

(Must be completed)

Agencies authorized to receive this information are the:

* U.S. Department of Health and Human Services;
* U.S. Social Security Administration;
* Illinois Departments of Human Services, Healthcare and Family Services, and Public Health;
* Other Illinois state agencies that operate a Medicaid Home and Community-Based Services waiver program;
* Illinois State Board of Education; and
* Local agencies under contract with DHS for the provision of service coordination, employer agent services or other supports and services which are involved in my individual service plan.

I understand that I have the right to look at and copy information about me that is released. I also understand that I have the right to refuse to release information but that DHS may still release information according to the Confidentiality Act and the federal Health Insurance Portability and Accountability Act (HIPAA).

Name of Individual (print or type): _____

Signature of Individual or authorized representative: _____

Signature of Witness: _____ Date: _____

CONFIDENTIALITY OF INFORMATION - Information received about the individual is to be handled in accordance with the requirements of the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and the federal Health Insurance Portability and Accountability Act (HIPAA).

(formerly DMHDD - 1214)