

Admissions Application

The Help Group

“Because Every Child Deserves A Great Future”

APPLICATION TO:

PACIFIC SCHOOLS

Pacific Ridge

The Pacific Ridge program is a therapeutic day school for students who are experiencing social and emotional distress interfering with their academic success. Students are in need of a highly structured therapeutic setting to address their mental health and behavioral needs. Common issues are oppositionality, defiance, school truancy, acting out, and risk-taking behaviors.

Note: An application is not needed at this time. Please contact our Admissions Office @ 818-779-5262 to schedule an appointment

Pacific Cove

The Pacific Cove program is a therapeutic day school for students with social and communicative disabilities, high functioning autism, and Asperger’s Disorder, as well as significant behavioral challenges. The program entails a highly structured behavior modification component along with multi-modal teaching methods.

DATE: _____

DATE OF APPLICATION: _____

I. STUDENT INFORMATION

STUDENT'S LAST NAME FIRST MIDDLE DATE OF BIRTH

STREET ADDRESS CITY STATE/ZIP HOME PHONE (____)

CURRENT RESIDENCE:

[] PARENT'S HOME [] RELATIVE/GUARDIAN [] OTHER _____
PLEASE SPECIFY

AGE: _____ MALE [] [] FEMALE

STUDENT'S PLACE OF BIRTH STATE COUNTRY

MOTHER'S NAME

FATHER'S NAME

STREET ADDRESS (if different than student's)

STREET ADDRESS (if different than student's)

CITY STATE ZIP

CITY STATE ZIP

(____) _____
HOME PHONE PAGER/CELL

(____) _____
HOME PHONE PAGER/CELL

E-MAIL ADDRESS

E-MAIL ADDRESS

STUDENT'S SOCIAL SECURITY #

MEDI-CAL or INSURANCE POLICY NUMBER

PREFERRED METHOD OF CONTACT:

PHONE [] E-MAIL [] EITHER []
(Circle: Home Cell Work)

III. MEDICAL HISTORY

Does the applicant have any chronic or serious health problems? [] YES [] NO

If yes, please describe:

Does the applicant have any health restrictions or limitations? [] YES [] NO

If yes, please describe:

Does the applicant have any allergies? [] YES [] NO

If yes, please describe:

Is there a history of the applicant taking medications? [] YES [] NO

If yes, please list.

<u>MEDICATION*</u>	<u>DOSAGE/TIMES</u>	<u>PRESCRIBING DR.</u>	<u>PURPOSE</u>
_____*	_____	_____	
_____*	_____	_____	
_____*	_____	_____	

***Please indicate month/year of initiation and month/year of discontinuation**

Has your child been hospitalized for any reason? [] YES [] NO (if yes, please explain below)

1. Reason: _____

Age: _____ DX: _____

Duration: _____

2. Reason: _____

Age: _____ DX: _____

Duration: _____

IV. SCHOOL HISTORY

NAME OF CURRENT SCHOOL	GRADE	CURRENT TEACHER'S NAME	
STREET ADDRESS		STATE	ZIP
CITY			
(____) _____		DATE STARTED	ENDING DATE
PHONE NUMBER			

Reason for seeking a new school placement: _____

Current Type of School	Current Type of Program
<input type="checkbox"/> Nonpublic	<input type="checkbox"/> Full-Inclusion Classroom
<input type="checkbox"/> Public School	<input type="checkbox"/> Full-Inclusion Classroom with resource pull-out (specify subject for pull-out)
<input type="checkbox"/> Private	<input type="checkbox"/> Special Day Class
	<input type="checkbox"/> Special Day Class with some mainstreaming (specify mainstreamed subjects)

Please check any current educational concerns:

<input type="checkbox"/> Difficulty with reading	<input type="checkbox"/> Difficulty with handwriting
<input type="checkbox"/> Difficulty with spelling	<input type="checkbox"/> Difficulty with arithmetic
<input type="checkbox"/> Difficulty with school attendance	<input type="checkbox"/> Difficulty maintaining attention
<input type="checkbox"/> Difficulty with abstract concepts	<input type="checkbox"/> Difficulty with organization (forgets homework, misses assignments)

Other (specify): _____

Please list all schools in which your child was placed prior to his/her current school. Also indicate if it was a special education program and the reason for discontinuation.

<u>Name of School</u>	<u>Grade(s)</u>	<u>Reg. Ed.</u>	<u>Special Ed.</u>	<u>Reason for Discontinuation</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has the child ever been in a Residential Treatment Center? Yes No
Where? _____ Dates: _____

Have you ever applied to any other Help Group school? Yes No
If yes, which school, and what was the outcome? _____

V. HISTORY OF INTERVENTIONS

A. Diagnosis

Does your child currently have a diagnosis (if so, what)? _____

Who diagnosed your child? _____ (_____) _____
Name Agency Phone Number

Date of diagnosis: _____

What prompted you to seek an evaluation? _____

B. Please reply only if your child has received services in any of the following areas:

1. Speech and Language _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention?

2. Counseling _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention? _____

3. Occupational Therapy _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention? _____

4. Educational Therapy or Tutoring _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention? _____

Please provide any assessments completed by the professionals above or any other assessments you may have.

PACIFIC COVE APPLICANTS ONLY

VI. ADDITIONAL INFORMATION

Describe your child's strengths.

For each question identified below, place an X in the box to the right that appropriately describes your child.	Often	Sometimes	Rarely	Never
1. My child prefers to do things with others rather than on his / her own.				
2. My child prefers to do things the same way over and over again.				
3. My child has been involved in fights at school.				
4. My child has been suspended from school.				
5. My child often notices small sounds when others do not.				
6. In a social group, my child can easily keep track of several different people's conversations.				
7. My child has made inappropriate sexual statements.				
8. My child has engaged in inappropriate sexual activities on one or more occasions.				
9. My child finds social situations easy.				
10. When my child talks, it isn't always easy for others to get a word in edgewise.				
11. My child finds it hard to make new friends.				
12. It upsets my child if the daily routine is disturbed.				
13. My child finds it easy to "read between the lines" when someone is talking to me.				
14. New situations make my child anxious.				

Please describe any behavioral problems that have been brought to your attention by the school staff.

VIII. ADDITIONAL INFORMATION

Describe your child's strengths.

What are your child's favorite activities?

Is your child involved in any extracurricular activities? [] YES [] NO (if yes please list)

Please describe your child's social relationships at home and at school.

Please describe any behavioral or attention problems that have been brought to your attention by the school staff.

Is there any additional information that you feel would be helpful in evaluating your child?

IX. IEP INFORMATION AND FUNDING SOURCE

Please enclose a copy of your child's **two most recent annual IEPs, and all subsequent addenda**. If your child does not have a current IEP, please state where you are in the IEP process. Do you currently have:

Valid I.E.P. with Non Public School designation YES NO

I.E.P. meeting with district to receive NPS funding YES NO

If IEP meeting set, please indicate date: _____

Mediation Agreement YES NO

If Mediation Agreement meeting set, please indicate date: _____

Fair Hearing YES NO

If Fair Hearing meeting set, please indicate date: _____

Will fund privately YES NO

ASSISTED/REPRESENTED BY: ___SELF ___ADVOCATE ___ATTORNEY

Name: _____

SEEKING PLACEMENT FOR: ___ASAP ___FALL ___SPRING ___SUMMER

X. REFERRAL SOURCE

Please provide the following information regarding the person or organization that referred you to The Help Group.

1. _____
NAME

2. _____
NAME

TYPE OF REFERRAL

TYPE OF REFERRAL

AGENCY

AGENCY

STREET ADDRESS

STREET ADDRESS

CITY STATE ZIP

CITY STATE ZIP

PHONE NUMBER

PHONE NUMBER