



MONARCH
TRANSITION SERVICES

Application for Admission
2016-2017

AUTHORIZATION FOR RELEASE OF INFORMATION TO MONARCH FACULTY

NOTE: This release of information form is used to secure consent for our Admissions Director to release information gathered in the Intake and Admissions process to the remainder of the Admissions Team of Monarch School. Your signature on this form indicates that you give your informed consent to Monarch faculty to access and use information gathered for this evaluation for admissions and treatment planning purposes. Additional forms can be used to specify community-based parties to which you may also wish to release information from this evaluation.

Applicant's First Name M.I. Last Name Date of Birth

Street Address (Apt. #)

City State Zip Code Telephone Number

initial here→ _____ **I/WE hereby authorize and request the Admissions Director to provide information about the above-named student to the Admissions Team of Monarch School, as specified below.**

initial here→ _____ **I/WE give permission for all information gathered about this student during the Admissions process to be used in guiding this student's admissions process and treatment planning at Monarch School. This information may include:**

- background and history,
- current treatment-related, functional, daily living, and physiological information, and/or
- test results.

initial here→ _____ **I/WE understand that the purpose of this release of information is to guide and instruct the Monarch School Admissions Team. In the case of students considered appropriate for admission by that Team, the purpose of this release of information will also be to guide and instruct Monarch faculty in developing preliminary programming for the assessed student.**

initial here→ _____ **I/WE understand that I/we have the right to inspect and copy the information to be disclosed.**

initial here→ _____ **I/WE understand that this written, informed consent can be revoked at any time. I/WE may do this at any time by notifying Monarch School in writing, but revocation of your consent cannot cover any information released with your permission before Monarch School received the revocation.**

initial here→ _____ **I/WE understand that unless I/we revoke this authorization, it will otherwise either expire within the time I/we have specified below (check one, please):**

- at the end of the present school year
- after 180 days
- other condition/event for termination of release (please specify): _____

Parent Signature (if student is under the age of 18)

Date

Legally Authorized Representative* Signature (if the student has a court appointed guardian or conservator, or an agent under a power of attorney or under Chapter 34 of the Texas Family Code)

Student Signature (if student is over the age of 18 and no Legally Authorized Representative is signing on their behalf)

*proof of authority must be submitted with this form

Witness

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person/parent to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Student's Name: _____

Authorization for Request of Information

INFORMATION

_____ Name of Student (First)	_____ M.I.	_____ Last Name	_____ Date of Birth
_____ Street Address, Apt. #		_____ City/State/Zip Code	_____ Telephone Number

AUTHORIZATION TO REQUEST AND RELEASE INFORMATION

I hereby authorize The Monarch School to request and/or release information from the confidential record of the above-named student. The information specified below is authorized to be exchanged between Monarch and the persons named below:

Primary Care Physician

Name: _____	Email: _____
Address: _____	Phone: _____

Psychiatrist

Name: _____	E-Mail: _____
Address: _____	Phone: _____

Psychologist/School/Other

Name: _____	Email: _____
Address: _____	Phone: _____

The following information from my student's records may be requested by or released to the Monarch School:

- | | |
|---|--|
| <input type="checkbox"/> Pertinent Summary of Educational Records | <input type="checkbox"/> All Educational records |
| <input type="checkbox"/> Pertinent Summary of Therapeutic Records | <input type="checkbox"/> All Therapeutic records |
| <input type="checkbox"/> Pertinent Summary of Psychiatric Records | <input type="checkbox"/> All Speech, Occupational Therapy and Language Records |
| <input type="checkbox"/> Psychological/Educational Test Results | <input type="checkbox"/> Discharge Summary |

For the Purpose of:

- Multidisciplinary Psychology Services Educational Services Other _____
- Coordination of Psychological Treatment and/or Educational Services

I acknowledge the following statements:

- This request for release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder.
- I have the right to inspect and copy the information to be disclosed.
- I understand I may revoke this authorization at any time by notifying The Monarch School in writing, but it will not have any effect on any information sent before The Monarch School received the revocation.
- I understand that this authorization will expire at the end of the current school year, unless otherwise indicated below:

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- I agree that a facsimile or photocopy of this authorization is as valid as the original.

SIGNATURES

Patient Signature (If over 18) _____	Date: _____
Parent/Guardian/Legal Representative Signature: _____	Date: _____
Witness (21 or older) Signature: _____	Date: _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person/parent to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. RAR 7/07 Ver. #3

APPLICATION FOR ADMISSION 2016-2017

Name of person completing this form _____

Relationship to applicant _____ Date of application _____

Indicate for which program(s) you are submitting this application:

- Transition Services Transitional Living

Applicant Information

Applicant's First Name Middle Last

Preferred Name Male/Female

Address

City State Zip Code Telephone Unlisted (Y / N)

Date of Birth Current Age Place of Birth

Current School School District Grade Level

Ethnic Background (For demographic purposes only)

- White/Caucasian Black/African American American Indian/Alaskan Native Asian
Hispanic or Latino Native Hawaiian or Other Pacific Islander Other

Bilingual Yes No Language(s) spoken at home

Religious Affiliation Mother Father Child

Applicant's Primary Physician Phone Fax

Current Psychologist Phone Fax

Current Psychiatrist Phone Fax

Financial Aid:

- Do you plan to apply for financial assistance? Yes No
Have you received financial assistance forms? Yes No

How did you hear about us? Please be specific. We want to thank our referral sources!

Name Address / Phone Number

Family Information

Parent 1: _____
Mother Father Stepmother Stepfather Legal Guardian Other

Home Address Home Phone

Employer/Company Address

Occupation Position/Title

Business Phone Business Fax Cell Phone E-mail Address
(Preferred for school correspondence)

Parent 2: _____
Mother Father Stepmother Stepfather Legal Guardian Other

Home Address Home Phone

Employer/Company Address

Occupation Position/Title

Business Phone Business Fax Cell Phone E-mail Address
(Preferred for school correspondence)

Parent 3: _____
Mother Father Stepmother Stepfather Legal Guardian Other

Home Address Home Phone

Employer/Company Address

Occupation Position/Title

Business Phone Business Fax Cell Phone E-mail Address
(Preferred for school correspondence)

Parent 4: _____

Mother Father Stepmother Stepfather Legal Guardian Other

 Home Address Home Phone

 Employer/Company Address

 Occupation Position/Title

 Business Phone Business Fax Cell Phone E-mail Address
 (Preferred for school correspondence)

Please indicate if appropriate:

Parents divorced Father remarried Mother remarried
Father deceased Mother deceased

If parents are separated or divorced, who has custody?

Mother Father Stepmother
Stepfather Legal Guardian Other _____

With whom does the applicant reside?

Mother Father Stepmother
Stepfather Legal Guardian Other _____

Who will be financially responsible for the applicant's tuition and fees?

Mother Father Stepmother
Stepfather Legal Guardian Other _____

To whom should bills be addressed?

Mother Father Stepmother
Stepfather Legal Guardian Other _____

To whom should general school correspondence be addressed?

Mother Father Stepmother
Stepfather Legal Guardian Other _____

Emergency Contact Information

Primary Contact: _____
 Name Relation to the Applicant

 Home Phone Cell Phone Business Phone E-mail Address

Secondary Contact: _____
 Name Relation to the Applicant

 Home Phone Cell Phone Business Phone E-mail Address

1. What is your understanding of the mission of The Monarch School?

2. What is the main reason you are requesting an application to Monarch School? In what areas do you see a need for improvement in the applicant's life?

3. What are your goals/expectations for the applicant?

4. How does the mission of Monarch School match the applicant's needs? Please be as specific as possible.

5. Briefly describe any physical disabilities or limitations that the admissions applicant may have:

Educational, Residential, and Employment History

1. Tell us the schools and types of classes the applicant has been in. Discuss any special programs or modifications and services that have been provided. Start with the first school attended.

Date(s) Grade Level Name of School/Location/Type Services/Modifications Received

2. At any time, was the applicant on an Individualized Educational Plan (IEP) overseen by a public school system? If yes, please include a copy with the application.

Yes, currently Yes, in the past No

3. What is your perception of the current and prior educational environments, including methods and teachers? Do you think they were a good fit for the applicant? Please tell us why or why not.

Date(s) School Opinion

4. What other alternatives are you exploring besides Monarch School?

5. Has the applicant received any trade, technical, or vocational training? If so, describe.

<u>Date(s)</u>	<u>Name of the School/Setting</u>	<u>Acquired Skill / Training / Level of Mastery</u>
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6. Residential History – If applicable, please list the applicant’s previous residential settings (group home, assisted living, etc.).

<u>Dates of Stay</u>	<u>Name of Facility</u>	<u>Type of Setting</u>
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7. Please describe any therapies or other services (with agency name) that may have been provided to the applicant at previous residential programs (physical therapy, restorative care, home health, etc.).

8. Additional comments regarding residential history:

9. Employment History – If applicable, describe the applicant’s history of employment.

<u>Date(s)</u>	<u>Name of Employer</u>	<u>Duties performed</u>	<u>Reason for Leaving</u>
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Medical/ Health History

Please list the types of medical coverage that the applicant has and provide the corresponding policy numbers (Insurances, Medicaid, Medicare, VA, etc.):

<u>Name of Provider</u>	<u>Policy Number</u>	<u>Expiration/Renewal Date</u>
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Name of Applicant's Primary Care Physician: _____

Physician's Phone: _____

Address: _____

Does the Applicant have a history of seizures? yes no

If yes: Type of seizures (grand mal, petit mal, other): _____

Date of 1st seizure: _____ Date of most recent seizure: _____

Seizure frequency: daily weekly monthly semi-annually other

Are the seizures suppressed or controlled by prescribed medication(s)? yes no

Please list any limitations or risks that may result from a seizure: _____

Additional Health Information

List any special dietary needs: _____

Date of last dental examination: _____

Does the applicant use any dental aides? (dentures, retainers): _____

Date of last eye examination: _____ Vision test results: _____

Does the applicant use any corrective vision aides? (glasses, contacts): _____

If the applicant has been hospitalized or had any minor/major surgeries completed, please describe:
Date Type of Procedure/Reason for Treatment

Please list any medications currently being taken by the applicant:

Medication: _____ **Medication:** _____

Dosage: _____ Dosage: _____

Times/Daily: _____ Times/Daily: _____

Prescribed By: _____ Prescribed By: _____

Condition: _____ Condition: _____

Began On: _____ Began On: _____

Medication: _____ **Medication:** _____

Dosage: _____ Dosage: _____

Times/Daily: _____ Times/Daily: _____

Prescribed By: _____ Prescribed By: _____

Condition: _____ Condition: _____

Began On: _____ Began On: _____

Medication: _____ **Medication:** _____

Dosage: _____ Dosage: _____

Times/Daily: _____ Times/Daily: _____

Prescribed By: _____ Prescribed By: _____

Condition: _____ Condition: _____

Began On: _____ Began On: _____

What diagnoses have been suggested for the applicant?

Please examine the list below and note applicant's experiences with any of these factors or conditions. If possible, note the year of occurrence and elaborate briefly on the severity or frequency of the condition.

Yes/No <small>(circle 1)</small>	Condition	Year(s)	Additional Description
Yes/No	Speech disorders		
Yes/No	High blood pressure		
Yes/No	Heart problems		
Yes/No	Diabetes		
Yes/No	Cancer		
Yes/No	Stroke		
Yes/No	Kidney disease		
Yes/No	Glaucoma		
Yes/No	Arthritis		
Yes/No	Sinus problems		
Yes/No	Headaches		
Yes/No	Hearing problems		
Yes/No	Asthma		
Yes/No	Digestive problems		
Yes/No	Fainting		
Yes/No	Balance problems		
Yes/No	Menstrual problems		
Yes/No	Muscular problems		

Yes/No (circle 1)	Condition	Year(s)	Additional Description
Yes/No	Polio		
Yes/No	Pneumonia		
Yes/No	Anemia		
Yes/No	Chicken pox		
Yes/No	Mumps		
Yes/No	High cholesterol		
Yes/No	Measles		
Yes/No	Pregnancy		
Yes/No	Hepatitis		
Yes/No	Thyroid problems		
Yes/No	Venereal disease		
Yes/No	Swallowing difficulty		
Yes/No	Sleep disorders		
Yes/No	Head injury		
Yes/No	Depression		
Yes/No	Use of prosthetics, canes, walkers, lifts, and other devices		
Yes/No	Other significant health concerns		

Current Functioning

1. Please tell us about the applicant's special interests, favorite activities, and accomplishments. Include any types of play, hobbies, sports, special activities, and accomplishments.

Is assistance/guidance needed for any recreational activities? If so, please describe.

2. Please tell us about the support services that the applicant is presently receiving; e.g., academic tutoring, occupational therapy, speech therapy, group therapy.

Type of Support

Name of Provider

Frequency of Service

Personal and Social Development

1. Reading, speaking, listening strengths:

Reading, speaking, listening limitations:

2. Does the applicant socialize well with others? Yes/No Explain:

3. How does he/she handle disagreements?

4. What is the applicant's history of dealing with frustration and other emotional regulation issues?

Please explain the frequency of meltdowns or shut-downs, the possible causes/environmental triggers, and the consequences of such activity.

What has worked to help the student regain emotional control?

What hasn't worked?

Activities of Daily Living

Please describe the applicant's abilities to perform the following activities. Be sure to include the level of assistance required (if applicable).

1. Mobility/ambulation:

2. Communicating needs:

3. Personal grooming and dressing:

4. Orientation/Disorientation:

5. Bowel and Bladder management:

6. Bathing/Showering:

7. Eating:

8. Awareness of time/day (clocks/calendars):

9. Use of public transportation:

10. Cooking:

11. Laundry and house cleaning:

12. Managing personal finances:

Tobacco/Alcohol Use

1. Does the applicant currently use tobacco products? Yes/No

If yes, please describe the frequency of usage:

2. Does the applicant consume alcoholic beverages? Yes/No

If yes, please describe the frequency of consumption:

3. Does the applicant have a history of drug dependency or abuse? Yes/No

If yes, please explain:

Sexual History

What is the applicant's history of sexual activity? Please explain:

Does the candidate understand the cause and effect relationship between sexual intercourse and pregnancy? Yes/No

Criminal History

Briefly list and describe all applicant's arrests, convictions, probations, probation violations, or pending criminal charges, if any:


Please attach a picture of the applicant to the front of the application

Terms and Conditions of Monarch School


- **Cancellation Policy:** Please contact the admissions office 24 hours in advance of your scheduled appointment with the Admissions Team should you need to cancel for any reason. If cancellation is not received within the requested period, you will incur a charge of \$200.00. Your attention to this policy is appreciated.
- This application is merely a request for admission. If offered a place, the applicant will receive such offer in writing, along with an enrollment contract that must be completed, signed and returned along with the \$500 enrollment fee to the school office.
- It is understood that places reserved in the school at the beginning of the year are taken for a whole year. No deduction from the year's fees may be made because of absence or for those who give up their place at any time during the year.
- Monarch reserves the right to exclude any student permanently or temporarily at any time, if the Head of School deems such action advisable, either in the interest of the pupil or for the good of the school.
- In the event that your child/ward requires a level of service more intensive than originally contracted for, additional costs will be reflected in the monthly billing after prior notification to the parents/guardians.
- In a limited number of cases, additional personnel may be assigned to a student's program if he/she needs temporary 1:1 work. These are additional costs incurred after prior arrangement with the parent(s)/guardian(s).
- Monarch School encourages applications from and admits students of any racial, ethnic, or religious background. Its programs and policies are applied with equal consideration to all of its applicants and students.

A parent's full obligation is outlined in the annual enrollment contract.


To the best of my knowledge, all information contained in this application is complete and accurate. I have read and I understand the Terms and Conditions of the Monarch School admissions process.




Parent Signature (if student is under the age of 18)



Date



Legally Authorized Representative* Signature (if the student has a court appointed guardian or conservator, or an agent under a power of attorney or under Chapter 34 of the Texas Family Code)



Student Signature (if student is over the age of 18 and no Legally Authorized Representative is signing on their behalf)

*proof of authority must be submitted with this form