ACCESSIBLE ACADEMICS
MAKING INDEPENDENCE ACCESSIBLE

Enrollment Application

STUDENTS: Complete this form if you are interested in receiving services from Accessible Academics. Please complete as fully as possible. Falsifying information or withholding information can result in non-acceptance into our program. While we understand the challenges that face individuals with special needs, we also are honest with students and families about the dedication and self control it takes to achieve more independence and a higher education. Students must be aware that they must adhere to the rules and codes of conduct not only of Accessible Academics, but also of the institution(s) they chose to attend.

If you are NOT the student applying for services but completing this on behalf of a student, please complete all sections to the best of your knowledge. We can work with you to help secure necessary documentation and information.

Each area requires a response. If not applicable, write "N/A". If you have questions or need help completing this application, please contact Melissa Heldwein, Transition Coordinator, at (716) 492-8656 Ext 1 or via email at mheldwein@accessibleacademics.org

When are you anticipating enrolling in postsecondary education?

(Month/Year): _____

If already enrolled, when did you begin? (Month/Year) _____

What areas are you seeking support in? (check all that apply):

Academic Skills____ Life Skills_____ *Job Skills _____ Social Skills _____

What Workshops are you interested in?

Life Skills _____ Academic Skills _____ Executive Functioning _____ Social Skills _____ *Job Skills _____

Note: If you are interested in Job Skills training and/or support, you must complete the **Supplemental Work History form and submit along with your application.*

YOUR BASIC INFORMATION

Last Name	First Name	Middle Initial
Mailing Address (street, city, state, zip code)		
Home Phone:		
Student's Cell:		
Student's Email:		
DOB:	Gender: M F Non Binary	
SSN:	Citizenship:	
Primary Language:	Race/Ethnicity:	

Best Time to Contact (Circle):		
Monday	Morning	Mountain
Tuesday	Afternoon	Pacific
Wednesday	Evening	Central
Thursday		Eastern
Friday		
Saturday		
Sunday		

PRIMARY FAMILY CONTACT

Please complete this section by providing contact information for the family member or close friend that currently supports you in your life the most. This person may be the entity that we enter into a Service Agreement with on your behalf for payment of services. Even if you have outside funding sources to pay for services, we do require that each student have one Trusted Adult contact, at minimum, to ensure that we have someone who we are able to communicate with about your progress in our program.

Please note - if you have a Legal Guardian as defined under Surrogate's Court (17a), this person MUST be listed as your primary family contact. Also, ensure to check the box for "Guardian" in addition to their relationship to you below.

Last Name	First Name	Middle Initial
Mailing Address (street, city, state, zip code)		
Home Phone:	Cell:	
Email:	Primary Language:	

SECONDARY FAMILY CONTACT

Complete this section if there is another actively involved adult within your life that you would like us to be able to connect with and share information about your services with.

Last Name	First Name	Middle Initial
Mailing Address (street, city, state, zip code)		
Home Phone:	Cell:	
Email:	Primary Language:	

EDUCATIONAL HISTORY

Required materials: High school transcripts, college transcripts (if applicable), SAT/ACT test scores (if applicable), IEP/504 (if applicable)

Most Recent High School	Dates Attended
Contact Person & Phone	Email
Highest Grade/Diploma Achieved	Did you receive Special Education Services? Yes ____ No ____

Have you ever been suspended or expelled from school? If so, please explain and provide year(s):
Have you ever attended, or are you currently attending, a post-secondary

institution (college, BOCES, technical school, etc.)?
Yes ____ **(If yes, complete the next pages)**
No ____ **(If no, go to page 7)**

POST SECONDARY EDUCATION

Provide information about any post secondary education you have received. If none, leave blank. Each section refers to a new institution. Please provide ALL necessary information about EACH institution attended.

Institution Type (#1) __ Community College __ Private University __ State University __ Technical State
Name of Institution: _____
Dates Attended: _____
of Credits Received: _____ GPA: _____
Major/Degree: _____
School Contact (Advisor, Counselor, etc. - include name, phone and email): _____

Institution Type (#2) __ Community College __ Private University __ State University __ Technical State
Name of Institution: _____
Dates Attended: _____
of Credits Received: _____ GPA: _____
Major/Degree: _____

School Contact (Advisor, Counselor, etc. - include name, phone and email): _____

Institution Type (#3) __ Community College __ Private University __ State University __ Technical State
Name of Institution: _____
Dates Attended: _____
of Credits Received: _____ GPA: _____
Major/Degree: _____
School Contact (Advisor, Counselor, etc. - include name, phone and email): _____

Institution Type (#4) __ Community College __ Private University __ State University __ Technical State
Name of Institution: _____
Dates Attended: _____
of Credits Received: _____ GPA: _____
Major/Degree: _____
School Contact (Advisor, Counselor, etc. - include name, phone and email): _____

MEDICAL INFORMATION

Please be as thorough as possible when completing this section. Note that a CURRENT (within past year) physical and Immunization Record must be on file with Accessible Academics, as well as a copy of any scripts for controlled substances and EpiPens.

List any medical conditions you have, including date diagnosed (if known):

_____
_____
_____
_____
_____
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_____
_____

List any medications you are currently taking & reason for use (include vitamins and over the counter products):

_____
_____
_____
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_____
_____
_____
_____

List any allergies (food, environment, animals, medications, etc.)

_____
_____
_____
_____

_____
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_____
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_____

Do you require the use of an EpiPen? Yes ____ No ____ Unsure ____

If yes, for what? (Describe allergic reaction and instructions for use of EpiPen)
_____
_____
_____

Have you had the immunizations needed for enrollment in college?
Yes ___ No ___ Unsure ____

Do you regularly take your medication(s) as prescribed? (If none, check "N/A")
Yes ___ No ___ Unsure ____ N/A ____

Do you need reminders to take and refill your medication(s)? (If none, check "N/A")
Yes ___ No ___ Unsure ___ N/A ___

MENTAL HEALTH INFORMATION

This section should be completed by the student, whenever possible. If not completed by the student, please fill in on the student's behalf to the best of your ability. Please be as honest as possible. We aim to serve students with mental health concerns as well as those with developmental disabilities. If a question does not apply, write N/A.

Do you have any concerns about the way you think, feel or behave? Do you have a mental health diagnosis? If you said yes to either of these, check "Yes" below. Otherwise, check "No"

Yes ___ No ___

Student's Mental Health Diagnoses (Check All That Apply):

Generalized Anxiety Disorder (GAD) _____
Obsessive Compulsive Disorder (OCD) ____
Bipolar I Disorder ____
Bipolar II Disorder ____
Schizophrenia ____
Schizoaffective Disorder ____
Tourette's Syndrome ____
Clinical Depression ____
Acute Depression ____
Seasonal Depression (SAD) ____
Post-Traumatic Stress Disorder (PTSD) ____
Social Anxiety ____
Attention Deficit Hyperactivity Disorder (ADHD) ____

No Known Mental Health Diagnosis ____

Please describe any mental health concerns you have. Even if you have not been diagnosed with a mental health disorder, explain your symptoms and how they interfere with your daily life:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What helps you cope with these symptoms (list all that apply; i.e., medication, talking, music, being alone, being with others, running,

meditation, etc.)?

What TRIGGERS your symptoms (list all that apply; i.e. crowds, noise, deadlines, clutter, social situations, perceived expectations, failure, etc.)?

Have you ever been hospitalized for mental health reasons? If so, please explain.

Have you ever attempted suicide? If yes, how long ago? Can you describe the circumstances?

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_____
_____
_____
_____
_____
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Do you regularly harm yourself? (Includes self-injury during meltdowns or behavioral outbursts) If so, please describe the nature of self-harm and approximate date of last occurrence.

_____
_____
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Do you experience “meltdowns” or behavioral outbursts? If so, how often do they occur? When was the approximate date of last occurrence?

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Have you ever damaged property or harmed another person during a “meltdown” or behavioral outburst? If so, please describe the circumstances and approximate date of last occurrence.

_____

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MENTAL HEALTH PROFESSIONALS

Complete this area in full. If none, write "N/A"

Do you have a Counselor or Psychologist? (Counselors and psychologist provide treatment through TALKING and use different forms of therapeutic techniques to help you cope with your symptoms). If you have one, please list their full name and phone number.

Name: _____ Phone: _____

Do you give permission to Accessible Academics to communicate with the above listed provider? (Check"No" if not applicable)

Yes ____ No ____

Do you have a Psychiatrist? (Psychiatrists provide treatment through MEDICATION and symptom management to help you cope with your symptoms). If you have one, please list their full name and phone number.
Name: _____ Phone: _____

Do you give permission to Accessible Academics to communicate with the above listed provider? (Check "No" if not applicable)

Yes ____ No ____

DEVELOPMENTAL HISTORY

Please be as accurate as possible in this section. The more information you give us, the better we can get to know you and how to support you. If you don't already have eligibility for state-funded services, we can use the information provided here to assist you in that process.

Do you have a Developmental Disability? If so, check all that apply (Please Note: In order for a diagnosis to be considered a "developmental" diagnosis, you must have been diagnosed prior to the age of 22).

Intellectual Disability ____
Autism Spectrum Disorder ____
Cerebral Palsy ____
Epilepsy ____
Familial Dysautonomia ____
Fetal Alcohol Syndrome (FAS) _____
Noonan Syndrome ____
Downs Syndrome ____
Prader-Willie ____
Developmental Delay _____
“Other Health Impaired” _____
Traumatic Brain Injury (TBI) _____
Other:
_____

Explain what your birth was like. Were you born early/pre-term? Did you need special treatment or have an extended stay in the hospital? (Ask someone who knows your history to help, if needed)
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_____
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At what age did you: walk, talk, feed yourself, dress yourself, shower yourself, etc? Please include as much detail as possible:

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What do you feel your biggest obstacles are in achieving your goals (i.e., transportation, communication, money management, organization, memory, specific subjects in school, making friends, etc.)?

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CRIMINAL & DRUG USE HISTORY

Please be honest in this section. Having a criminal record can impact the types and amounts of funding you can receive for school and other supports.

Have you ever been convicted of a felony? Yes ____ No _____

If yes, please explain circumstances, including sentence (i.e. prison time, jail time, probation, community service, etc.):

Do you now, or have you ever, had a problem with drugs or alcohol, including dependency on prescription medications?

If yes, please explain. Include treatment provided to assist you in recovering.

SERVICE ELIGIBILITY

Do you have OPWDD eligibility?
Yes _____ No _____ I'm Not Sure _____
If yes, are you receiving services from an agency?
Yes _____ No _____
If yes, do you have a Self Directed Plan? Yes _____ No _____
If yes, complete:

Service: _____
Agency: _____
Contact Person: _____
Phone: _____

Service: _____
Agency: _____
Contact Person: _____
Phone: _____

Service: _____
Agency: _____
Contact Person: _____
Phone: _____

Comments:
_____
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_____

Do you have an ACCES-VR Counselor?
Yes _____ No _____ I'm Not Sure _____

If yes, name: _____
Phone: _____

REFERENCES/SUPPORTS

Please list two people that you feel are supportive of you that do not live with you currently (i.e., friend, aunt, neighbor, etc.).

Name:	Relationship to you:	Phone/Email:
Name:	Relationship to you:	Phone/Email:

STUDENT NARRATIVE

Using a few sentences, please explain what your personal goals are for yourself:

_____

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Please attach any/all supporting documentation to this application when returning. Supporting documentation can include any of the following:

- IEP/504 from high school
- Transition Summary from high school
- High School transcript
- TASC or other high school equivalency scores
- SAT/ACT scores
- College transcripts
- Accommodation letter from higher education
- Most recent psychological evaluation
- Most recent physical, including vaccine records

AUTHORIZATION/CERTIFICATION

I certify that the information I have provided is truthful and complete. By signing this, I am authorizing Accessible Academics to contact all schools, references, and professionals that I have listed.

Signature of Applicant

Guardian (if applicable) Date

All Completed Enrollment Applications can either be:

1. Scanned and emailed to: ashowers@accessibleacademics.org AND mheldwein@accessibleacademics.org
2. Mailed to: **Accessible Academics**
   P.O. Box 590
   Amherst, NY 14226

Questions? Call us at (716) 492-8656

For Office Use Only:
Date Received: _____ CEO Review: _____
Next Step Approved: _____