TOPS Application Part One: Instructions

Transition Options in Postsecondary Settings for Students with Intellectual/Developmental Disabilities (TOPS)
The Ohio State University Nisonger Center

Application for Admission

We are excited that you’ve decided to pursue the TOPS Program at The Ohio State University; we ask that you complete the following application for admission to our program. TOPS admission process occurs in three phases, which include Application, Document Review, and Selection and Enrollment. Applicants and/or parents are welcomed to meet with program staff to discuss individual needs at any time in this process.

Application Due Date:
Applications will be accepted on an on-going basis.

Phase One: Application
The purpose of the Admission Application is to identify applicants who may be viable students for TOPS. This is accomplished through the submission of an application, including submission of items listed on the application checklist.

Application Checklist

☐ Complete TOPS application containing signature of the participant and/or guardian as appropriate.
☐ An official transcript of the applicant’s high school coursework (official transcripts have an embossed seal or signature from an authorized staff person from your school)
☐ An official copy of the applicant’s IEP or 504 Plan. If statewide testing accommodations are not included in the IEP, a separate copy is required.
☐ Most current Evaluation Team Report (ETR)
☐ Up-to-date psychological evaluation (within the past two years)
☐ Complete health evaluation with the applicants physician’s signature
☐ Proof of health insurance
☐ Personal essay
☐ Personal letter of recommendation
☐ Professional letter of recommendation

Phase Two: Document Review
The purpose of the Document Review is to identify the applicant’s potential for success in TOPS. During this phase, program managers may contact the applicant, parents, and/or references for clarification or additional information. If it is determined that the applicant has met all of the admission criteria and all application documentation has been submitted, a recommendation for enrollment will be forwarded to the selection committee for consideration.

Phase Three: Selection and Enrollment
The selection committee - consisting of the program managers, the director or designee from the Office for Disabilities Services (ODS), and members from the interdisciplinary team - will meet to review applications and conduct individual interviews with applicants and their families.

**Residential College Orientation & Transition Assessment (COTA) Program**

If an applicant is selected for TOPS, a letter of acceptance will be sent to the applicant, as well as an invitation to participate in the summer COTA program. The summer COTA program will include the cost of the dorms, meals, supplies, technology, and facilitators. In order to hold your reservation in the Residential COTA program, a deposit of $250.00 must be received. Payment for the COTA program must be received no later than June 1st.

After a successful summer experience, a person-centered planning (PCP) meeting will be conducted prior to the semester’s expected start date. The purpose of the PCP meeting is to coordinate services among adult agencies and Ohio State, set goals, develop a Transition Action Plan and determine the level of needed supports. In addition, we will discuss a list of potential internships along with the minimum number of hours students will spend engaged in work experiences per week. The student’s program of study will be developed, which will list the required and potential courses the student may be interested in auditing.

Applicants may submit this packet through any one of the following methods, along with a nonrefundable $60 application fee made payable to the Ohio State University Nisonger Center.

- **Send materials to:**
  Special Education and Transition Department
  Shannon Prince, Program Assistant
  257 McCampbell Hall
  1581 Dodd Drive
  Columbus, OH 43210
  **E-mail:** Shannon.Prince@osumc.edu
  **Fax:** 614-366-6373

- **Drop-off:**
  Application packets can be hand delivered to Shannon Prince in the Transition Office, 257 McCampbell Hall.

For more information, or an alternative format of this application, please contact Shannon Prince by phone at 614-685-3185 or e-mail.

**Non-Discrimination Policy**

The Ohio State University is committed to building a diverse faculty and staff for employment and promotion to ensure the highest quality workforce, to reflect human diversity, and to improve opportunities for minorities and women. The university embraces human diversity and is committed to equal employment opportunity, affirmative action, and eliminating discrimination. This commitment is both a moral imperative consistent with an intellectual community that celebrates individual differences and diversity, as well as a matter of law.

Discrimination against any individual based upon protected status, which is defined as age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, sexual orientation, or veteran status, is prohibited.
TOPS Application Part Two: Personal Information

Applicant Information

Name ____________________________________________________________

Last                                      First

Address __________________________________________________________

Street                                      City                State                ZIP Code

Home # ___________________________ Cell # ___________________________ Work # ________________

E-mail __________________________________________ Fax # (optional) ________________________

Date of Birth ____________________________  Are you your own Guardian? □ Yes □ □No

Parent/Guardian/Stakeholder

Name ____________________________________________________________

Last                                      First

Address __________________________________________________________

Street                                      City                State                ZIP Code

Home # ___________________________ Cell # ___________________________ Work # ________________

E-mail __________________________________________ Fax # (optional) ________________________

Relationship to Applicant ________________________________

Release of Information

If the applicant is own guardian:
By signing, I consent that members of the TOPS selection committee can have access to my high school records, all content of this application, and may speak with and/or obtain relevant records from family members, stakeholders, school, and agency personnel as a part of my application review.

___________________________________________  ____________________________
Applicant Signature                               Date

If the applicant is not own guardian:
By signing, I agree that members of the TOPS selection team can have access to my daughter’s/son’s high school records, all content of this application, and may speak with and/or obtain relevant records from family members, stakeholders, school, and agency personnel as a part of my daughter’s/son’s application review.

___________________________________________  ____________________________
Parent/Guardian Signature                         Date
Applicant is referred to TOPS by self, parent, teacher, or stakeholder. Please complete the following information.

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<thead>
<tr>
<th>Applicant Name</th>
<th>Current High School</th>
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<tr>
<th>Name of Person Making Referral</th>
<th>Phone Number</th>
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<tr>
<th>Relationship to Applicant</th>
<th>E-mail</th>
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</table>

By signing below, the applicant and/or guardian agree that:

- ✔ Applicant meets the admission criteria to enroll in the TOPS program.
  - Applicant, family, or stakeholders are able to provide the $60.00 admissions application fee to The Ohio State University, Office of Distance Education & eLearning.
- ✔ Applicant, family, or stakeholder is able to provide or willing to seek financial support to purchase textbooks, materials, university and program fees, if applicant is accepted into the TOPS program.

_________________________________________  _______________________
Signature                                      Date
Education

Date of high school graduation:
______________________________________________________
(If applicant has not yet graduated high school, please specify the expected graduation date above.)

Level of school participation (please choose one):

☐ Fully included in regular courses
☐ Partially included in regular courses
☐ Attended special education courses only
☐ Attended special facility

Does the applicant have previous post-secondary experience?  ☐ Yes (please specify)  ☐ No

Institution name: _____________________________________________________________

Dates attended: __________________________________________________________________

Employment

Please check all that apply:

☐ Applicant currently has a paid or unpaid job.

Employer ___________________________ Hours per week __________________
Supervisor ___________________________ Phone # __________________

☐ Applicant has had a paid or unpaid job.

Employer ___________________________ Hours per week __________________
Supervisor ___________________________ Phone # __________________

☐ Applicant currently volunteers at one or more sites.

Site ___________________________ Hours per week __________________
Supervisor ___________________________ Phone # __________________

Position: ___________________________

Volunteer Responsibilities______________________________________________________

__________________________________________________________________________
Site __________________________ Hours per week __________________
Supervisor __________________________ Phone # __________________
Position __________________________
Volunteer Responsibilities __________________________

General Skills

Although participants are not required to be independent in all aspects of their life in order to be eligible for TOPS, increasing overall independence is an area of emphasis for participants to become integrated within campus life. Please check all that apply:

☐ Applicant takes medication and is able to do so without supervision.

☐ Applicant takes medication, but needs support to do so (describe support needed).

☐ Applicant is able to use the restroom independently.

☐ Applicant needs support in the restroom (describe support needed).

☐ Applicant is able to manage stress and adapt to changing environments on his or her own.

☐ Applicant needs support in managing stress and/or navigating changing environments (describe support needed).

☐ Applicant is able to cook and prepare meals independently.

☐ Applicant needs support in cooking and preparing meals (describe supports needed).
☐ Applicant is able to do his/her own laundry independently.

☐ Applicant needs support in order to do his/her own laundry (describe supports needed).

___________________________________________________________________________

___________________________________________________________________________

☐ Applicant is able to use his/her own telephone to communicate with others independently.

☐ Applicant needs support in using his/her own telephone to communicate with others (describe supports needed).

___________________________________________________________________________

___________________________________________________________________________

Support Information

What kind of support is the applicant currently receiving? Please check all that apply:
☐ None
☐ Provider
☐ Counseling
☐ BVR or service eligibility
☐ Vocational Rehabilitation
☐ County Board of Developmental Disabilities Services
☐ Other (please specify)________________________________________________________

If applicable, please provide the name and telephone number of your support counselor:
___________________________________________________________________________

___________________________________________________________________________

What kind of financial assistance is the applicant currently receiving? Please check all that apply:
☐ None
☐ Supplemental Security Income (SSI)
☐ Social Security Disability Insurance (SSDI)
☐ Waiver (please specify)_______________________________________________________
☐ Other (please specify)_______________________________________________________

Would the applicant be interested in receiving need-based funding or scholarships?  ☐Yes  ☐No
Transportation Checklist

Although participants are not required to be independent in community travel to be eligible for TOPS, increasing independent travel is an area of emphasis for participants to become integrated within campus life. Please check all that apply:

☐ Applicant uses public transportation independently.

☐ Applicant is willing to learn how to use public transportation.

☐ Applicant uses door-to-door or Para-transit systems (e.g., Mainstream) and can independently make own reservations.

☐ Applicant uses door-to-door or Para-transit systems (e.g., Mainstream), however requires assistance in making reservations.

☐ Applicant has a family member or others who are able to provide ongoing transportation.

☐ Applicant is eligible for disability-related transportation assistance.

☐ Applicant is able to cross intersections with pedestrian signals safely and unassisted.

☐ Applicant is able to cross intersections that do not have pedestrian signals safely and unassisted.

☐ Applicant is able to move independently and safely in a parking lot or garage.
TOPS Application Part Three: Essay and References

Personal Essay

☐ Please write and attach a personal essay that answers each of the following questions.
(Applicants may submit essays using multimedia (e.g., video, PowerPoint, etc.), electronic or written formats. Traditional essays, drawings, pictures, photos, poetry, songs, interviews, or other alternative means of expression may be used to answer the questions listed above.)

- How would attending college help me fulfill my dreams or a goal I have for myself?
- How would participating in the TOPS Program help me become more independent?
- How would attending Ohio State make my life better? Answer this question by thinking of what resources are available to you through the TOPS program and Ohio State exclusively.

Optional

- Up to 10 additional photos of you engaged in activities, school, work or community events, current or past, can be included
- A Student Portfolio DVD can also be included

Letters of Recommendation

All applications must include one personal and one professional letter of recommendation. Each person must complete the recommendation form and write a formal recommendation letter.

☐ Letter of Recommendation, Personal

A personal letter of recommendation can be written by a friend, family member, neighbor or any other person who has a primary personal relationship with the applicant. The letter should specifically address the applicant’s character, skills, motivation and potential.

☐ Letter of Recommendation, Professional

A teacher, employer, coach or any other person who has a primary professional relationship with the applicant can write a professional letter of recommendation. The letter should specifically address the applicant’s character, skills, motivation and potential.

Please limit letters of recommendation to a single page, double-spaced, Times New Roman 12 point font and one-inch margins. Letters should be dated and signed and submitted with the application.
### Personal Recommendation Form

Applicant’s Name: 

Recommenders Name: 

Relationship to Applicant: 

E-mail: 

Length of Time Known:

(Please check the appropriate box)

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<thead>
<tr>
<th>Skills</th>
<th>Does not perform the skill</th>
<th>A lot of prompting needed</th>
<th>Little prompting needed</th>
<th>Self-Sufficient</th>
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<tr>
<td>Social Skills</td>
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<td>Participates in small groups successfully</td>
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<td>Respects others’ opinions</td>
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<td>Time Management</td>
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Please provide any additional information you feel might be useful:
## Professional Recommendation Form

Applicant’s Name:  

Recommender’s Name:  

Relationship to Applicant:  

E-mail:  

Length of Time Known: 

(Please check the appropriate box)

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Please provide any additional information you feel might be useful:
TOPS Application Part Four: Medical Information

TOPS Medical History Form

General Information

Applicant’s First and Last Name: ________________________________
Gender: □ Male □ Female Date of Birth: ________________
Age: ____________________
Parent/Guardian’s Name: ________________________________
Address: _____________________________________________ City: ________________
State: ______ ZIP Code: ________ E-mail: ____________________
Phone: Home: ________________ Cell: ________________ Work: ________________

Emergency Contact Information

Name: ____________________ Relationship: ____________________
Phone: Home: ____________________ Work/Other ____________________

Insurance Information

Insurance Carrier: _________________________________________
Group/Plan Number: ____________________ Phone: ____________________
Personal/Family Physician: ____________________ Phone: ____________________

Medical Conditions

Do you wear contact lenses? __________ glasses? __________ hearing aid? __________
Do you have asthma? __________ If so, do you use medication? __________ If yes, please specify:

Do you have any physical disabilities or limitations that we need to be aware of for this program? If so, please describe the disability, limitation and history:

Do you have any special needs that we should be aware of that may affect your participation in the program (e.g. fears, second language, ADD, Asperger’s…)? Please explain:

Do you have any other condition that we should be aware of that may endanger, alter or somehow limit your ability to participate in our programs? Please describe in detail:
## Medications

Please list current prescription and non-prescription medications, vitamins, supplements.

<table>
<thead>
<tr>
<th>Medication/Vitamin/Other</th>
<th>Dose</th>
<th>Times per Day</th>
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## Allergies

Please list any allergies that you have.

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<tr>
<th>Allergies</th>
<th>Reaction</th>
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</table>

Do you use medication for allergic reactions? ________________  
If so, what do you use? ____________________________
**Proof of Immunization**

This form **must** be completed and signed by a physician. A complete immunization record from a physician or clinic may be attached to this form.

Applicant’s First and Last Name: __________________________________________________________

Date of Birth: ___________________ Date of Form Completion: ___________________

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Reason</th>
<th>Check if applicant received immunization</th>
<th>Date received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal Vaccine (MCV4)</td>
<td>To protect against meningococcal disease</td>
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<tr>
<td>Hep B</td>
<td>To protect against hepatitis B</td>
<td></td>
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<tr>
<td>Inactivated Polio Vaccine (IPV)</td>
<td>To protect against polio</td>
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<tr>
<td>DTaP</td>
<td>To protect against diphtheria, tetanus (lockjaw) and pertussis (whooping cough)</td>
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<tr>
<td>Hib Vaccine</td>
<td>To protect against Haemophilus influenza type B</td>
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<tr>
<td>MMR</td>
<td>To protect against measles, mumps and rubella</td>
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<tr>
<td>Pneumococcal vaccine</td>
<td>To protect against pneumonia, infection in the blood and meningitis</td>
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<tr>
<td>Varicella</td>
<td>To protect against chicken pox</td>
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<tr>
<td>Rotavirus</td>
<td>To prevent infections caused by rotavirus</td>
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<tr>
<td>Hep A</td>
<td>To protect against hepatitis A</td>
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<tr>
<td>Immunization</td>
<td>Reason</td>
<td>Check if applicant received immunization</td>
<td>Date received</td>
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<tr>
<td>HPV (females)</td>
<td>To protect from human papillomavirus</td>
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<tr>
<td>Seasonal influenza</td>
<td>To protect against different flu viruses</td>
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</tbody>
</table>

Date of last tetanus booster: __________________________

____________________________________________________
Signature of Physician/Physician Assistant/Nurse Practitioner Date

____________________________________________________
Office Address

City __________________________  State __________  ZIP Code __________

____________________________________________________
Office Phone Number