TOPS Residential College Orientation and Transition Assessment (COTA) Program for Students with Intellectual and Developmental Disabilities

Application for Admission

☑ Are you a high school student who will be graduating in the next 2 years and want to begin planning for your future?
☑ Are you considering going to college after high school?
☑ Are you interested in competitive or community employment that matches your preferences and interests?
☑ Would you like to take advantage of the diverse opportunities available on a college campus to help you engage socially in your community?

The TOPS program is offering a 7 day residential College Orientation and Transition Assessment program in June of 2018 for high school students who expect to graduate in the next 2 years or who have recently graduated.

During this 7 day program, students will be given focused batteries of assessments that evaluate student skills related to college readiness, career awareness, technology usage, and life skills. Students will be introduced to the academic behaviors that are needed to participate in college classes, connect personal interests to careers/jobs, be exposed to how to use technology to maximize skills in his/her daily routines, and gain awareness of needed life skills (i.e., accessing transportation, money management and utilizing support services).

The one-week summer program costs $1,500.00 and includes the cost of the dorms, meals, supplies and facilitators. Payment must be received no later than May 1st in order to hold your reservation in the summer program.

To get started, we ask that you complete the following application for admission to our summer program.

Application Due Date: March 31st

Admission Process
The entire admission process occurs in three phases which include Application, Document Review, Selection and Enrollment
Phase One: Application

Application Checklist

☐ Complete TOPS Residential College Orientation and Transition Assessment Program Application
☐ An official copy of the applicant’s IEP/504 and most current Evaluation Team Report (ETR).
☐ Proof of health insurance
☐ Recommendation Form
☐ Non-refundable $250 deposit

Phase Two: Document Review

The purpose for the document review is to obtain evidence that identify the applicant’s current levels of functioning and needed supports. This is accomplished by program staff conducting a thorough review of required supported documentation. If the applicant is determined to have met all the criteria and all application documentation has been submitted, a recommendation for enrollment will be forwarded to the selection committee for consideration for enrollment in the residential COTA program.

Phase Three: Selection and Enrollment

The Screening Committee – consisting of the program managers, the director or designee from the Office for Disabilities Services (ODS), and members of the interdisciplinary team – will meet after the application deadline to review applications and conduct individual interviews if needed with applicants and their parents. Notification of the Screening Committee’s decision and invitation to participate will be sent by mail by April 15th.

Applicants may submit this packet through any one of the following methods:

- Send materials to:
  OSU Nisonger Center-Transition Department
  257 McCampbell Hall
  1581 Dodd Drive
  Columbus, OH 43210
  Transitions@osumc.edu
  614-685-3185 phone; 614-366-6373 fax

- Drop-off:
  Application packets can be hand delivered to the program assistant in the Transition Office, 257 McCampbell Hall

For more information, or an alternative format of this application, please contact our office by phone at 614-685-3185, or e-mail Transitions@osumc.edu.

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 Residential College Orientation and Transition Assessment Program

Application

Student Name: _____________________________________________________________________

Street Address: ___________________________________________________________________

City: ________________________________ State: _________________ Zip: _______________

Primary e-mail: ____________________________________________________________________

Student Phone number: (home) _________________________ (cell) _______________________

Gender (circle one):        Male      Female        Current Age: ______________________

Current rank in School (circle one):                                                                                   Current GPA: __________
                                   Junior               Senior       Additional High School Years____   High School Graduate

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

Primary Disability (please be specific):
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Secondary Impairments (as the result of primary disability):
________________________________________________________________________________
________________________________________________________________________________

Name of school:
________________________________________________________________________________

School Address:
________________________________________________________________________________

Phone Number: _________________________ Fax: _________________________

Anticipated graduation date: _____________________ Age at graduation: ___________________
Which college disciplines are you interested in?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

What career areas and occupations interest you and why?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Please list any internship/work/volunteer experience and how they have shaped your future goals:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Please list any Universal or Assistive Technology you are currently using:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Parent/guardian’s name (if not own guardian or under the age of 18):
__________________________________________________________________________________

Phone number: (home) __________________________ (cell)________________________________

Email: ___________________________________________________________________________

Street Address: __________________________________________________________________

City: _____________________________ State: __________ Zip: _______________
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 IEP or 504 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 IEP or 504 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
Medical Information

Proof of Insurance: (Please provide copy of insurance card)

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: ______________________________________________________________

Please check whether you have an intellectual or developmental disability?

Intellectual disabilities ________ Developmental disabilities ________

Do you have any additional disabilities that must be considered when identifying supports? If so, please describe the disability, limitation and history:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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 program (e.g., walking, communicating, toileting, and attention span)? Please describe in details:

________________________________________________________________________________

________________________________________________________________________________
Medications

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

**Note:** Program staff and facilitators cannot administer medication to students. If the applicant is currently taking medications of any sort, a Medical Action Plan (MAP) must be completed and submitted to program staff no later than the first day of the residential program.

<table>
<thead>
<tr>
<th>Medication/Vitamin/Other</th>
<th>Dose</th>
<th>Times per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Allergies

Please list any allergies that you have.

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</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.

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

Date of last tetanus booster: __________________________

__________________________  __________________________
Signature of Physician/Physician Assistant/Nurse Practitioner  Date

__________________________
Office Address

__________________________  __________________________  __________________________
City  State  ZIP Code

__________________________
Office Phone Number  Fax
**Recommendation Form**

Student Name:  
Recommender’s Name:  
Relationship to Student:  
Email:  
Length of Time Known:  
Phone Number:  

( Please check the appropriate box )

<table>
<thead>
<tr>
<th>Skills</th>
<th>Does not perform the skill</th>
<th>Needs a lot of prompting</th>
<th>Little prompting needed</th>
<th>Self-Sufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participates in small groups successfully</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respects others opinions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manages own sensory needs appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is prompt to class or appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meets deadlines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creates and follows schedules</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Advocacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeks assistance when unsure or confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>States opinions and relays needs clearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking Style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handles constructive criticism well</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows how thyself learns best</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breaks large tasks into small, workable parts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes initiative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sets obtainable goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapts to a change of routine effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide any additional information you feel might be useful.