



TRANSITION OPTIONS IN POSTSECONDARY SETTINGS
FOR STUDENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

**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 6-day residential College Orientation and Transition Assessment program in June of 2023 for high school students who expect to graduate in the next 2 years or who have recently graduated.

During this 6-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 13th 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: April 15th

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
- ☐ 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 email by April 29th.

Applicants may scan & email or post mail this packet to the following address below:

- **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

For more information, or an alternative format of this application, please contact our office by phone at 614-685-3185, or e-mail Transitions@sumc.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):
 Junior Senior Additional High School Years _____ High School Graduate

Current GPA: _____

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 member 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 detail:

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.

Medication/Vitamin/Other	Dose	Times per Day

Allergies

Please list any allergies that you have.

Allergy	Reaction

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: _____

Immunization	Reason	Check if applicant received immunization	Date Received
Meningococcal Vaccine (MCV4)	To protect against meningococcal disease		
Hep B	To protect against hepatitis B		
Inactivated Polio Vaccine (IPV)	To protect against polio		
DTaP	To protect against diphtheria, tetanus (lockjaw) and pertussis (whooping cough)		
Hib Vaccine	To protect against Hemophilus influenza type B		
MMR	To protect against measles, mumps and rubella		
Pneumococcal vaccine	To protect against pneumonia, infection in the blood and meningitis		
Varicella	To protect against chicken pox		
Rotavirus	To prevent infections caused by rotavirus		
Hep A	To protect against hepatitis A		

Immunization	Reason	Check if applicant received immunization	Date Received
HPV (females)	To protect from human papillomavirus		
Seasonal influenza	To protect against different flu viruses		

Date of last tetanus booster: _____

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Office Address

City

State

ZIP Code

Office Phone Numb

