Admission Application

Waiver

Congratulations on your decision to apply to The College Experience! The College Experience a two-year residential, non-credit certificate program hosted by The College of Saint Rose in partnership with Living Resources. Through the College Experience, students with intellectual disabilities can practice living independently, make friends, intern at area businesses and become part of a diverse campus community.

Below is a checklist that you can use as your guide, as you complete each step in the application process. We look forward to hearing from you!

APPLICANT DIRECTIONS

1. Complete the application. ***(Not to be completed by parents or service coordinators.)***
   To submit your application, **print** and then either **fax** (518-862-2175), **mail** or **scan & email** to Colleen Dergosits (cdergosits@livingresources.org).
2. Please fill out and submit a **Medicaid Waiver** (at the end of this application).
3. Submit an independently written, **one-page typed essay** stating why you would like to be part of The College Experience.
4. Ask your high school to send the following documents:
   - High School Transcript
   - Individualized Education Plan (IEP)
   - Psychological Evaluation (Most Recent)
5. Have two individuals that are familiar with your abilities complete the **Recommendation Form**. These individuals could be teachers, job coaches, job supervisors, day habilitation specialists.
6. Have your parent/guardian complete the **Assessment of Daily Living Skills Form**.

If mailing documents, please send to:

The College Experience Program
Attn: Colleen Dergosits
Living Resources Corporation
300 Washington Avenue Extension
Albany, NY 12203

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ADMISSIONS PROCESS

1. Application paperwork is reviewed by CEP admissions team.
   - Applicants are approved, deferred or denied
2. Approved applicants are asked to come for an overnight visit.
   - Visits are successful or unsuccessful
3. Applicants that complete a successful overnight visit are asked to interview with the CEP admissions team.
4. Approved applicants are asked to attend a final interview with The College of Saint Rose.
5. Applicants receive an Acceptance or Denial Letter.

OUR GOAL FOR GRADUATES

- To live with minimal support in their own apartment.
- To financially support themselves by working a part- to full-time job.
- To plan and engage in recreational activities with friends.

MINIMUM REQUIREMENTS FOR ADMISSION

Enrollment in OPWDD Medicaid Waiver and Social Security Income is required.

1. Commitment to live independently with minimal support.
   - Ability to be at home without supervision
   - Some experience of being independent in the community
2. Motivated to integrate by participating in a variety of social and educational activities sponsored by The College of Saint Rose and organized by the CEP Community Coordinator.
3. Ability to independently complete all daily living tasks.
   - Examples: Waking up, hygiene, dressing, chores, etc...
4. Motivated to learn and participate in discussions and conversations with instructors and students.
5. Motivated to independently complete in-class assignments and homework.
6. Ability to get along with others, follow house and school rules, accept supervision.
7. Ability to use a calculator to do basic math.
8. Ability to read at a minimum of a third grade level.
9. Ability to type a document on Microsoft Word, experience using search engines (i.e. Google), experience using email.

Admission to The College Experience Program is **competitive**.

Candidates for admissions will be asked to participate in an interview and may be required to provide “on-demand” writing and reading samples. Acceptance into the program requires the recommendation for acceptance by Living Resources to The College of Saint Rose. Final acceptance into the program is determined by The College of Saint Rose.

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APPLICANT INFORMATION

Expected Year of Enrollment
(All students start in the fall)

Last Name | First Name | Middle Initial

○ Male ○ Female

Birthday

Phone Number | Email Address

Social Security Number | Country of Birth

Home Address | City

State/Province | Zip | County

Are you enrolled in the NY START Program? ○ Yes ○ No

PARENT/GUARDIAN INFORMATION

Parent/Guardian Type ○ Father ○ Mother ○ Guardian

Last Name | First Name | Middle Initial

Phone Number | Email Address | Occupation

Parent/Guardian Type ○ Father ○ Mother ○ Guardian

Last Name | First Name | Middle Initial

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LIFE AT HOME

Do you stay home alone? ○ Yes ○ No

Do you go out alone? ○ Yes ○ No

Have you ever lived away from home? ○ Yes ○ No

If yes, when and where? _____

What do you use to make food at home? *(Select all that apply and provide examples next to each.)*

☐ Oven _____ ☐ Stove _____

☐ Microwave _____ ☐ None - only sandwiches and snacks

What is your favorite food to prepare? _____

What chores do you complete at home? *(Select all that apply.)*

☐ Take Out Trash ☐ Dishes ☐ Vacuum

☐ Clean Up Bedroom ☐ Dust ☐ Laundry

☐ Other _____

MEDICAL INFORMATION

Do you take medication? ○ Yes ○ No Do you take these independently? ○ Yes ○ No

Drug	Dosage	Time of Dispense	Comments

Do you self-manage medication? ○ Yes ○ No

If no, please describe daily support given: _____

List all allergies / reactions (food, environmental, medications): *Please note if you require an EpiPen for any of these allergies.*

Do you have a history of a seizure disorder? ○ Yes ○ No

If yes, please attach seizure protocol.
Please note, we cannot administer Diastat.

Do you currently receive private counseling? ○ Yes ○ No

If yes, what is the frequency? _____

Any additional medical needs that were not inquired about that would be important to share?

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LIFE AT SCHOOL

Name of High School | City and State | Year of Graduation | Diploma Received

Did you have a behavior support plan? *If yes, please attach.* ○ Yes ○ No

What type of services did you receive in high school? *(Select all that apply.)*

- ☐ Self-Contained Classes
- ☐ Resource Room
- ☐ Consultant Teacher
- ☐ Counseling
- ☐ Inclusion Classes
- ☐ Speech
- ☐ Adaptive Physical Education (PE)
- ☐ Occupational Therapy (OT)
- ☐ Physical Therapy (PT)
- ☐ Other _____

What was your favorite subject? _____

What was your least favorite subject? _____

What areas will you need extra help in? _____

What areas are you interested in learning more about? _____

What activities were you involved with in and out of school? _____

If you have attended any school or program after high school, please fill out information below.

Name of School/Program | City and State | From-To Dates

JOB / VOLUNTEER EXPERIENCE

If you wish, you may attach a resume separately.

Job Title | Company

From - To Dates | How did you get there? ○ Paid ○ Volunteer

Job Title | Company

From - To Dates | How did you get there? ○ Paid ○ Volunteer

Job Title | Company

From - To Dates | How did you get there? ○ Paid ○ Volunteer

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PERSONAL INFORMATION

Disability Classification: _____

What are your strengths? _____

_____

_____

What areas do you struggle with? _____

_____

_____

What do you want to be doing five years from now? _____

_____

Any history of, or current legal difficulties? ○ Yes ○ No If yes, please explain: _____

_____

Have you ever been convicted of a misdemeanor or felony? ○ Yes ○ No

If yes, please explain and provide dates: _____

_____

Any history of, or current difficulties with violence to self, others, or property? ○ Yes ○ No

If yes, please explain and provide dates: _____

_____

Any history of, or current substance abuse? ○ Yes ○ No If yes, please describe: _____

_____

Are you your own legal guardian? ○ Yes ○ No If no, who is your legal guardian? _____

Have you ever run away before? ○ Yes ○ No If yes, please explain: _____

_____

Have you ever been hospitalized for psychological reasons? ○ Yes ○ No

If yes, please provide dates and reason for hospitalization: _____

REFERRAL INFORMATION

Who told you about The College Experience?

_____ _____

Last Name First Name

_____ _____

Phone Number Relationship to You

By signing below, I certify all information is true and correct to the best of my knowledge. Omission to information or false reporting could lead to dismissal after admission.

_____ _____

Applicant Signature Date

Medicaid Waiver

Please fill out the information below. Then **print** and either **fax** (518-862-2175), **mail** or **scan & email** to Colleen Dergosits (cdergosits@livingresources.org).

Please remember to include:

- Notice of Decision Letter to show that you are Medicaid Waiver enrolled
- Letter of Determination of Eligibility for OPWDD Services
- Individualized Service Plan (ISP)
- SSI Benefit Letter
- DDP2

APPLICANT INFORMATION

Last Name _____ First Name _____

Medicaid Number _____ TABS ID Number _____

Do you receive Supplemental Security Income (SSI)? ○ Yes ○ No

CARE COORDINATOR INFORMATION

Last Name _____ First Name _____

Agency _____ Phone Number _____ Email _____

ADDITIONAL AGENCY INFORMATION (IF APPLICABLE)

Last Name _____ First Name _____

Agency _____ Phone Number _____

Applicant Signature _____ Date _____

If mailing documents, please send to:

The College Experience Program
Attn: Colleen Dergosits
Living Resources Corporation
300 Washington Avenue Extension
Albany, NY 12203