



THE UNIVERSITY *of* NORTH CAROLINA
GREENSBORO

Inspire. Change.



330 South Greene Street Suite 303
Greensboro, NC 27401
336.288-8115
beyondacademics.uncg.edu

APPLICATION PROCESS

- 1. 2012-13 Academic Year Deadline: February 1, 2012**
2. A review of the application for eligibility is conducted by the Admissions Committee. Questions are resolved through conversation with the prospective student and his/her parent or legal guardian.
3. Prospective students must have a documented diagnosis of an Intellectual Disability to be considered for admission. If a prospective student has not been assessed for service eligibility, the student is referred to a Developmental Disabilities Case Management agency for assessment.
4. Prior to full-time admission to UNCG, prospective students must have concluded their secondary education. Although certifications are not required, copies of any earned certificates should be attached to the application.
5. Two letters of recommendation from non-relatives are required. Student applicants should include letters from people who know their level of motivation to become as independent as possible and who have known the applicant for at least six months.
6. A personal interview is held with prospective students and their parents or legal guardian. The purpose of the interview is to confirm eligibility requirements and commitment from the student and parents/legal guardian for a two to four year individualized course of study.
7. If accepted, the student begins the Admissions/Enrollment Process with the UNCG registrar, with support from Beyond Academics

Student		
Name:	Date of Birth:	
Address:		
City:	State:	Zip Code:
Home Phone:		
Day Phone:	Evening/Night Phone:	
Email address:		
Parents		
Mother Name:	Day Phone:	
	Evening/Night Phone:	
Address:		
City:	State:	Zip Code:
Father Name:	Day Phone:	
	Evening/Night Phone:	
Address:		
City:	State:	Zip Code:
Mother Email Address:	Father Email Address:	
Legal Guardian		
Do you have a legal guardian? ___No ___Yes:		
Name:		
Relationship to Applicant:		
Address:		
City:	State:	Zip Code:
Day Phone:	Evening/Night Phone:	
Email Address:		
I live with: ___my parent(s) ___other relatives ___in a group home ___on my own or with a roommate		
Other (describe):		

SERVICE PROVIDER INFORMATION

PLEASE ATTACH A PERSON-CENTERED PLAN WITH APPLICATION (completed within the past year)

Note: Your current service provider will not be contacted without your signed consent

Attached is my most recent Person-Centered Plan

I do not have a Person-Centered Plan.

Are you currently receiving CAP-MR/DD Services? Yes No

If Yes, Service(s):

Home/Community Support Personal Care Residential Respite Other:

Have you applied for CAP-MR/DD Services? Yes No Waiting List Not eligible

If you currently receive services, what is your current service provider agency?

Provider Agency Name: _____

Provider Address: _____

Provider Contact Name: _____ **Phone:** _____

Are you receiving Case Management Services? Yes No

Case Management Agency: _____

Case Management Agency Address: _____

Case Manager Name: _____ **Phone:** _____

Email Address: _____

HEALTH INFORMATION:

I currently take the following medications:

- | | | |
|-----------|----------------|-----------------|
| a. | Dosage: | Purpose: |
| b. | Dosage: | Purpose: |
| c. | Dosage: | Purpose: |
| d. | Dosage: | Purpose: |

Do you need support managing your medication? ___ Yes ___ No
If yes, what level?

Disability/Medical Diagnosis:

Behavioral Diagnosis:

Other Information About My Health and Disability:

PERSON-CENTERED INFORMATION: The below questions should be answered by the potential student with assistance only if needed

Long-Term Goals: How do you want your life to look within the next five years?

Strengths: What are you good at doing? What do people admire about you? What are your talents and gifts?

Preferences: What is important to you? What really matters in your life?

Needs: What would you like to change about your life? What is not working in your life?

Supports: What is important to you to be successful, healthy and safe?

PROGRAM RELATED INFORMATION: The below questions should be answered by the potential student with assistance only if needed

Why do you want to be a student at UNCG?

What do you look forward to in college?

What fears do you have regarding college?

What questions do you have about the campus?

FOR PARENTS OR LEGAL GUARDIAN TO COMPLETE:

I am: ___ a parent of the applicant ___ a sibling ___ other relative ___ a non-related guardian

Why do you think this applicant (your son, daughter or other relation) is interested in attending classes in the Integrative Community Studies course of study at UNCG, with support from Beyond Academics?

**What situations are upsetting to this person that we need to be aware of?
(i.e. thunderstorms, dogs, loud noises, etc)**

What are your concerns relating to college?

What suggestions do you have for us regarding motivators for this applicant? For example, if s/he is hesitant to attend classes or participate in student activities, what do you recommend?

What are three skills (priority) you like to see this student accomplish during his/her college career? (be specific)

1.

2.

3.

Please check the most appropriate response(s) as it relates to this applicant:

When walking down the street, s/he will remain on the sidewalk:

- only if someone walks beside him or her
- with constant reminders
- with occasional reminders
- independently

When at a crosswalk, s/he will:

- cross the street without regard to safety
- wait for someone to tell them when to cross the street
- cross the street by using safe street crossing skills

Upon waking in the morning, if s/he found that they were the only person awake in the apartment, s/he would:

- leave the apartment without regard to safety
- remain in the apartment and wait for someone to assist them
- safely begin a daily routine in the apartment
- call or wake someone to ask what to do next

Is there anything else important to know about your son or daughter?

Campus Safety Questions (Required for All Applicants)

Your “yes” answer to one or more of the following questions will not necessarily preclude your being admitted. However, your failure to provide complete, accurate, and truthful information will be grounds to deny or withdraw your admission, or to dismiss you after enrollment. For the purpose of the following six questions, “crime” or “criminal charge” refers to any crime other than a traffic-related misdemeanor or infraction. You must, however, include alcohol or drug offenses whether or not they are traffic related.

- a) Have you been convicted of a crime? Yes No
- b) Have you entered a plea of guilty, no contest, “*nolo contendere*,” or an Alford plea, or have you received a deferred prosecution or prayer for judgment continued, to a criminal charge? Yes No
- c) Have you otherwise accepted responsibility for the commission of a crime? Yes No
- d) Do you have any criminal charges pending against you? Yes No
- e) Have you ever been expelled, dismissed, suspended, placed on probation, or otherwise subject to any disciplinary sanction by any school, college, or university? Yes No
- f) If you have ever served in the military, did you receive any type of discharge other than an honorable discharge? currently serving never served Yes No

If you answered “yes” to any of the six questions above, explain the circumstances on a separate sheet of paper.

Furthermore, you must promptly notify the Office of Undergraduate Admissions in writing of any criminal charge; any disposition of a criminal charge; any school, college, or university disciplinary action against you; or any type of military discharge (other than an honorable discharge) that occurs at any time after you submit this application. Failure to do so will be grounds to deny or withdraw your admission, or to dismiss you after enrollment.

Student Signature

Date

Guardian Signature (if applicable)

Date

REQUIRED ATTACHMENTS:

- **Recent Psychological Evaluation or other documentation with diagnostic information**
- **Most current Person Centered Plan (within the last year, if applicable)**
- **Signed forms: AUTHORIZATION TO RECEIVE HEALTH INFORMATION**
- **2 Letters of Recommendation from non-relatives**
(Please have references mailed directly to the Admissions Office)

Send Completed Application to:

Beyond Academics
Admissions Office
330 South Greene Street Suite 303
Greensboro, NC 27401

336.288-8115
emarshburn@beyondacademics.org

Beyond Academics
AUTHORIZATION TO RECEIVE HEALTH INFORMATION

Client Name: _____ **Record #:** _____ **Medicaid #:** _____ **DOB:** _____

I request and authorize:

_____ *Person/agency* _____ *address* _____ *phone #*

to share the specified health information in my records with **Beyond Academics, 330 S Greene St. Suite 303, Greensboro, NC 27401. (Fax: 336-288-8127)**

This consent to share information is (initial box): reciprocal to disclose only to receive only

Information to be **received** from _____ is indicated below by **my initials** next to each item...

_____ x Admission /screening /discharge summaries _____ Financial reimbursement
_____ x Psychiatric/psychological evaluations _____ x Medication/health information
_____ x Educational information i.e. IEP/behavior plan _____ x Verbal exchange
_____ x Diagnostic tools i.e. SNAP/IPRS _____ x Guardianship information
_____ x Person Centered plan _____ x MR2
_____ Other: _____

Information to be **released** by Beyond Academics is indicated below by **my initials** next to each item.

_____ x Admission/Discharge summaries _____ x Progress summaries _____ x Information related to goals
_____ x Info related to health and safety _____ Financial
_____ Other: _____

For the purpose of: _____ x Service Delivery _____ x Client request _____ Legal _____ x Referral
_____ Benefits Maintenance _____ x Coordination of services _____ x Maintaining student's health and safety
_____ Other: _____

Expiration Date : _____ (not to exceed one year) **Revoked on:** _____ *Staff Signature*

Student Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

_____ x I understand that this information is released and protected by the HIPPA Privacy Law (45 C.F.R., parts 160 and 164); the Federal Confidentiality Law (42 C.F.R., part 2); and the North Carolina Confidentiality Law (G.S., 122-C). The doctrine of informed consent has been explained to me, and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled, but not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ x I understand that the health information used and disclosed may include information such as alcohol abuse, drug abuse, psychological or psychiatric conditions.

_____ x **REDISCLASURE:** Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstance where disclosure is permitted or required by these laws.

_____ x **NOTICE OF VOLUNTARINESS:** I understand that signing this form is completely voluntary and that I have the right to refuse signature. If I choose not to sign this form, I understand that Beyond Academics cannot deny or refuse to provide treatment, payment, enrollment in health plan, or eligibility for benefits on my refusal to sign.

_____ x I authorize the release of information regarding **HIV or AIDS** related conditions Yes No

_____ x I was **offered a copy** of this release form and received this copy on _____ declined a copy

x _____
Student

x _____
Date

x _____
Legal Representative

x _____
Date

Beyond Academics Staff

Date

REVOCATION: Sign below **ONLY** if you are revoking your Authorization

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. (If I want to revoke this authorization I must do so in writing.) The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Beyond Academics Notice of Privacy Practices, a copy of which has been provided to me.

Student Signature: _____ Date: _____

Legal Representative Signature: _____ Date: _____

Witness: _____ Date: _____ Revocation Date: _____