

On Campus Transition Residential Program

Application

Section 1: Personal Information

A. Participant's Information

Name of Participant _____ Nickname _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Alternate Phone _____

Date of Birth _____ Age _____ Sex _____

Social Security Number _____

Primary Disability _____

Secondary Disability _____

B. Parent Information

Participant resides with: Mother Father Both Foster Parent Group Home

Other _____

1. Mother's Information

Name _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Alternate Phone _____

Email Address _____

2. Father's Information

Name _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Alternate Phone _____

Email Address _____

Section 2: A little bit about you

Hobbies and Interests

Put a check in the column that is most like you.

	I already do this	I would like to try this	This is not for me
Cooking or baking			
Art and Crafts			
Gardening			
Reading			
Writing			
Go to the beach			
Boating			
Going to the movies			
Singing or playing an instrument			
Dancing			
Acting			
Going to concerts or theatre performances			
Playing board games			
Decorating			
Working out			
Playing golf			
Playing tennis			
Playing basketball			
Playing soccer			
Playing volleyball			

Playing softball or baseball			
Swimming			
Watching sporting events			
Running or jogging			
Walking			
Going to museums			
Going to amusement parks			
Eating out with friends			
Shopping			
Watching TV			
Other activities:			

1. Are there any clubs or organizations that you currently participate in? If yes, please list them

2. Are you a member of a religious organization and would like to participate in religious services? If yes, please provide religious organization.

Transportation Skills Checklist

Put a check in the column that is most like you.

	I already do this	I would like to try this	This is not for me
How to read a map			
How to use a city bus schedule			
How to ride the city bus			
How to ask others for directions			
How to ride JTA Connexions			
How to schedule rides with JTA Connexions			
Other:			

1. Independent Street Crossing: (Check off what you are able to do independently)

None Crosses 4 lane street w/light Crosses 2 lane street w/light

Crosses 4 lane street w/out light Crosses 2 lane street w/out light

Specifics/Comments: _____

Financial Management

1. Do you recognize money? (Differences between one dollar bill compared to a 20 dollar bill, quarters versus nickels, etc.). Please explain.

2. Are you able to count money? Estimate cash back from transactions? Explain.

Please check the column that is most like you.

	I know how to do this by myself	I have done this some of the time but need some help	I have never done this and need training
Using cash to purchase items at a store			
Using a calculator to estimate costs during shopping (i.e., calculating sales tax and total items)			
Using a debit card			
Keeping track of debit card spending (i.e., keeping receipts and recording spending)			
Using a credit card			
Keeping track of credit card spending (i.e., keeping receipts and recording spending)			
Developing a budget			
Remaining within a budget			
Balancing a checkbook			
Organize wallet			

Please provide any additional information that would be helpful for OCT staff regarding your abilities and challenges in financial management.

Household Chores

	I know how to do this by myself	I have done this some of the time but need some help	I have never done this and need training
Dusting			
Sweeping			
Vacuuming			
Cleaning mirrors			
Polishing			
Washing dishes by hand			
Using a dishwasher			
Doing laundry			
Ironing			
Cleaning bathtubs			
Cleaning toilets			
Removing stains from carpets			

Please list any additional chores activities that you know how to do and/or require further assistance in learning. _____

Culinary Skills

	I know how to do this already without any assistance	I have done this before but need some assistance	I require a lot of assistance
Cutting vegetables			
Cutting meats			
Using a microwave			
Using an oven			
Using a stove			
Following simple recipes			

1. What types of breakfast meals do you usually eat?
2. What types of breakfast meals are you able to prepare by yourself without assistance?
3. What types of lunch and dinner meals do you usually eat?
4. What types of lunch meals are you able to prepare by yourself without assistance?
5. Have you ever made meals from the following semi-prepared meal boxes: Hamburger Helper, Campbell's, Pasta Side Dishes, etc.? If yes, how did it turn out?
6. What type of meals would you like to learn how to cook?
7. Are you generally safe in using a knife to cut vegetables, fruits, and meats?
8. Do you know how to use kitchen appliances in a safe manner? Please describe.

9. What are your favorite types of meals and foods?

10. What is your favorite type of restaurant? (ex. Italian, Chinese, Japanese, Mexican, etc.).

11. Do you ever eat frozen foods? If so, which ones? (ex. Lean Cuisines, Hot Pockets, Stouffers, etc.).

12. What foods do you not like?

13. Do you think that you eat a healthy balance between fruits, vegetables, meats, and dairy products?

14. Are you currently on a diet? If yes, please describe (ex. Weight Watchers)?

15. Are you able to follow a diet?

16. What are your nutrition goals?

17. Do you need to follow a special diet due to food allergies or illnesses, such as diabetes? If yes, please describe the diet.

Stamina and Endurance

Please check the item that describes you the best

1. Strength – Lifting and Carrying:

Poor(<10 lbs) Fair(10-20 lbs) Average(30-40 lbs) Strong(>50 lbs)

Specifics/Comments:

2. Endurance in completing tasks: (without breaks)

Works <2 hours Works 2-3 hours Works 3-4 hours

Specifics/Comments:

3. Orienting:

Small Area One Room Several Rooms Building Wide Building & Grounds

Specifics/Comments:

4. Physical Mobility: (Please check all that apply)

Sit/stand Fair ambulation Difficulty with stairs/minor obstacles Full mobility

Specifics/Comments:

5. Gross Motor Ability:

Full Fair Minimal

Specifics/Comments:

6. Fine Motor Ability:

Full Fair Minimal

Specifics/Comments:

7. Independent Work Rate: (no prompts)

Slow pace Steady/average Above average/sometimes fast pace Continual fast pace

Specifics/Comments:

8. Attention to task/perseverance:

Frequent prompts required

Intermittent prompts/low supervision required

Intermittent prompts/high supervision required

Infrequent prompts/low supervision required

Specifics/Comment

9. Independent Sequencing of Job Duties:

Cannot perform tasks in sequence Performs 4-6 tasks in sequence

Performs 2-3 tasks in sequence Performs 7 or more tasks in sequence

Specifics/Comments:

10. Initiative/Motivation:

Always seeks work Sometimes volunteers Waits for direction Avoids next task

Specifics/Comments:

11. Adapting to Change:

Adapts to change Adapts to change with great difficulty Rigid routine required

Adapts to change with some difficulty

Specifics/Comments:

12. Do you need prompting (Verbally) to complete a task? If so, what kind of prompting do you need and how much? Please additionally list some specific task that needs to be prompted on.

13. What positive reinforcements work best to keep you motivated and continuing the completion of tasks? (Ex. Verbal praise, candy, trip to the store, etc.).

14. What is the best way for the Housing Assistant to motivate you to accomplish a goal or follow instructions?

Functional Skills

Please check off what applies to you. Please provide comments and explanations.

1. Time Awareness:

Unaware of time and clock function Can tell time to the hour

can Identify breaks and lunch Can tell in hours and minutes

Specifics/Comments:

2. Functional Reading:

None Sight words/symbols Simple reading Fluent reading

Specifics/Comments:

3. Functional Math:

None Simple counting Simple addition/subtraction Computation skills

Specifics/Comments:

3. Following Directions or Instructions: (Please check all that work best for you)

Detailed written instructions Simple written instructions
 Simple written instructions with pictures Simple checklist with pictures
 Simple checklist without pictures Repetition Modeling (use of demonstrations)

Hygiene Routines

Please describe your full daily hygiene routine and procedures (also list level of assistance needed, for instance, prompting, modeling, or picture schedule). Please indicate when you prefer to take showers (am or pm).

What is the best way for others to help you wake up in the morning?

What is the best way to assist you in going to bed?

What time do you usually go to sleep?

What is the best way to motivate you in engaging the hygiene routine?

Personality and Interpersonal Relationships

1. Please check-off the given answer(s) that best describe your personality:

I am very talkative

I am quiet

It takes me some time to open up to people

I like being around a lot of friends

I like to be myself sometimes

I get nervous when I am in large crowds

I find it easy to make friends

I like to go to parties

I rather stay home and read a book

I am happy most of the time

I sometimes get depressed or anxious

I can be moody sometimes

I get angry a lot

I am always able to see the bright side of everything

I know how to entertain myself

I prefer quiet environments

I am not afraid to try new things

1. Handling Criticism/Stress: (Please indicate how you react)

___Resistive/argumentative

___Withdraws into silence

___Accepts criticism/does not change behavior

___Accepts criticism/changes behavior

Specifics/Comments:

2. What event/activities make you feel upset?

3. What is the best way for you to cope when you are upset?

4. Do you have any fears or phobias? Do these fears or phobias interfere with daily activities in your life?

5. How well do you generally get along with others?

6. What is the best way to help you during mood swings?

7. Please provide additional insight into your personality and the way you interact with others that would be helpful for LIFE Experience staff in assisting you with socialization skills training activities and facilitating friendships:

Please Read and Sign

I understand that this application is for admission to The On Campus Transition Residential Program. By signing this document, I am certifying that the information given is complete and accurate, and I understand that to make false or fraudulent statements within this application may result in denial of admission. If admitted, I hereby agree to abide by the policies, rules, and regulations of The On Campus Transition Residential Program.

Applicant's Signature _____ **Date** _____

Parent/Guardian's Signature _____ **Date** _____

Ensure that all sections have been completed.

Student Name: _____

Year: _____

OCT Residential Program

Medical/Emergency Contact Information

Please take the time to fill out all areas of this form.

In preparing for the OCT Residential Program, we must ensure that students have complete emergency contact information listed and that all medical necessities are listed

DOB: _____ Social Security: _____

Student Home Address:

Student Email Address (if student would like to receive email in an account other than the one provided by UNF): _____

Student Cell phone: _____ Student Home Phone: _____

Primary Contact Person: _____ Relationship: _____

Contact information (please list home address, email address, and all telephone numbers):

Alternative Contact Person: _____ Relationship: _____

Contact information (please list home address, email address, and all telephone numbers):

MEDICAL INFORMATION:

1. Does the student currently receive private therapeutic services, such as physical therapy, occupational therapy, psychiatry, speech therapy, or behavioral therapy? If yes, please list below with physician/therapist name and contact information:

In case a medical emergency or situation occurs, please provide the following information:

2. Provide a brief description of student's medical history, including disability diagnosis that the student has and /or suspects to have):

3. Please list any significant medical and/or physical conditions that may impact the student's participation in classroom, social, or recreational activities on campus (for example: severe allergies or visual disability)

4. Please list any current medication(s) the student is taking (Include dosage, frequency, and reason for taking the medication(s) as well as, any current or/suspected side effect(s) caused by medication(s): **(* Please note that if the student is independent in self-administering his/her medications and remembering to take his/her medication. Please indicate strategies used to assist student in remembering and/or how to take medications if student has difficulty).**

5. Does the student have seizures? Yes No

Type _____ Duration _____

Frequency _____ Date of last seizure _____

Are seizures controlled with medications? Yes No

4. Please list any assistive technology that you use (i.e., wheelchair, eyeglasses, prosthesis, walker, hearing aid, roll aid, etc.):

5. Please Provide the Following Current Information:*

Family or Primary Physician:

NAME: _____ Address: _____

Telephone: _____ Office Hours _____

Medical Insurance Name: _____

Policy Number: _____

Hospital Preference _____

Please provide any other medical information that you feel would be important regarding the student's participation in this program. Please Specify.

*If your student is not a Duval, Clay, and/or St. Johns County primary resident, then it is required that the student obtains a local Jacksonville physician and that a preferred local hospital is identified. The OCT recommends that St. Luke's Hospital (St. Vincent's Healthcare), located on 4201 Belfort Road, Jacksonville, FL.

Emergency Tree:

In case of an emergency, the following will be used as an emergency calling tree for your students. Please fill in requested information:

1. If student incurs an injury that requires immediate medical attention, 911 will be called.
2. The OCT staff will notify the Program Director and the first listed primary contact person.
3. If the primary contact person is unavailable, OCT staff will attempt the alternative contact person.
4. Please list other names and contact information of individuals that can be granted permission for OCT staff to contact in case of a student emergency:
 - a. Name _____
 - i. Relationship to student _____
 - ii. Telephone Number(s) _____

iii. Address _____

b. Name _____

i. Relationship to student _____

ii. Telephone Number(s) _____

iii. Address _____

c. Name _____

i. Relationship to student _____

ii. Telephone Number(s) _____

Address _____