

Admissions Application

The Help Group

Because Every Child Deserves a Great Future

PACIFIC SCHOOLS

□ Pacific Ridge Program: The Pacific Ridge program is a therapeutic day school for students who are challenged by social and emotional issues that interfere with their academic success, including oppositionality, defiance, school truancy, and acting-out or risk-taking behaviors. Pacific Ridge provides students with a structured therapeutic setting to address their mental health and behavioral needs.

□ Harbor School West Program: The Harbor School is a therapeutic day school for students who are experiencing social and emotional distress that interfere with their academic progress and success in a public school setting, but who do not exhibit significant disturbances of behavior. Common issues are depression, anxiety, difficulty with school attendance, and peer relational problems.

Please contact our Admissions Office at 818-779-5262 to schedule an intake appointment.

PLEASE RETURN YOUR APPLICATION AND ALL DOCUMENTS TO:

The Help Group
Admissions Office
13130 Burbank Blvd.
Sherman Oaks, CA 91401

Si necesita ayuda en español, por favor llame al 818.779.5207.

DATE OF APPLICATION: _____

I. STUDENT INFORMATION

STUDENT'S LAST NAME FIRST MIDDLE DATE OF BIRTH

STREET ADDRESS CITY STATE/ ZIP HOME PHONE (____)

STUDENT'S CURRENT RESIDENCE

With both parents With mother With father Other: _____
PLEASE SPECIFY

AGE: _____ MALE FEMALE

STUDENT'S PLACE OF BIRTH STATE COUNTRY

MOTHER'S NAME

FATHER'S NAME

STREET ADDRESS (if different than student's)

STREET ADDRESS (if different than student's)

CITY STATE ZIP

CITY STATE ZIP

(____) (____)
HOME PHONE CELL

(____) (____)
HOME PHONE CELL

E-MAIL ADDRESS

E-MAIL ADDRESS

Best way to contact:
 Phone: Please specify: Home Work Cell
 E-mail

Best way to contact:
 Phone: Please specify: Home Work Cell
 E-mail

STUDENT'S SOCIAL SECURITY #

MEDI-CAL or INSURANCE POLICY NUMBER

II. FAMILY INFORMATION

MOTHER'S WORK INFORMATION

NAME OF BUSINESS

JOB TITLE/POSITION

STREET ADDRESS

CITY STATE ZIP

WORK PHONE NUMBER EXTENSION

FATHER'S WORK INFORMATION

NAME OF BUSINESS

JOB TITLE/POSITION

STREET ADDRESS

CITY STATE ZIP

WORK PHONE NUMBER EXTENSION

SIBLINGS

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

OTHER HOUSEHOLD MEMBERS

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

♦ Is child adopted? No Yes: At what age? _____

♦ Languages spoken in the home: _____ Primary language: _____

♦ *If parents are separated or divorced:*

Date of separation or divorce: _____ Child's age at time of divorce: _____

Current custody arrangement: _____

III. MEDICAL HISTORY

♦ Does child have any chronic or serious health problems?

No Yes: Please specify: _____

♦ Does child have any health restrictions or limitations?

No Yes: Please specify: _____

♦ Does child have any allergies?

No Yes: Please specify: _____

♦ Does child currently take any medications? No Yes: Please list below:

| <u>Name of Medication</u> | <u>Dosage/Frequency</u> | <u>Prescribing Doctor.</u> | <u>Purpose</u> |
|---------------------------|-------------------------|----------------------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

♦ Has child taken other medications in the past? No Yes: Please list below:

♦ Has child been psychiatrically hospitalized? No Yes: Please list below:

Name of hospital: _____ Dates/Duration of stay: _____

Reason: _____

Name of hospital: _____ Dates/Duration of stay: _____

Reason: _____

IV. SCHOOL HISTORY

| | | | |
|-------------------------------|--------------|------------------------|-----|
| NAME OF CURRENT SCHOOL | GRADE | CURRENT TEACHER'S NAME | |
| STREET ADDRESS | CITY | STATE | ZIP |
| (_____) _____ PHONE NUMBER | DATE STARTED | | |

♦ Reason for seeking a new school placement: _____

♦ Current type of school: Nonpublic Public Private

♦ Current type of program: Regular ed classroom Regular ed classroom with resource pull-outs
 Special day class Other: _____

♦ Please check any current educational concerns:

- | | |
|--|---|
| <input type="checkbox"/> Difficulty with reading <input type="checkbox"/> Difficulty with spelling <input type="checkbox"/> Difficulty with school attendance <input type="checkbox"/> Difficulty with abstract concepts <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> Difficulty with handwriting <input type="checkbox"/> Difficulty with arithmetic <input type="checkbox"/> Difficulty maintaining attention <input type="checkbox"/> Difficulty with organization (forgets homework, misses assignments) |
|--|---|

♦ Please list all schools in which your child was placed prior to his/her current school:

| <u>Name of School</u> | <u>Grade(s)</u> | <u>Reg. Ed.</u> | <u>Special Ed.</u> | <u>Reason for Discontinuation</u> |
|-----------------------|-----------------|-----------------|--------------------|-----------------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

♦ Has child ever been in a Residential Treatment Program? No Yes: Please specify:
 Name of residential program: _____ Dates: _____

Reason: _____

♦ Has child ever applied to any other Help Group school? No Yes: Please specify:
 Which school, and what was the outcome? _____

V. HISTORY OF INTERVENTIONS

DIAGNOSIS

Does your child currently have a diagnosis? No Yes: Please specify:

Who diagnosed your child? _____ (_____) _____
Name Agency Phone Number

Date of diagnosis: _____

What prompted you to seek an evaluation? _____

SERVICES RECIEVED

♦ Has your child ever received counseling or therapy? No Yes: Please specify:

_____ (_____) _____
Name of therapist/counselor Agency Phone number

_____ (_____) _____
Name of therapist/counselor Agency Phone number

♦ Has your child ever received Speech and Language Therapy? No Yes: Please specify:

_____ (_____) _____
Name of service provider Agency Phone number Dates of service

What were the goals of this service? _____

♦ Has your child ever received Occupational Therapy? No Yes: Please specify:

_____ (_____) _____
Name of service provider Agency Phone number Dates of service

What were the goals of this service? _____

♦ Has your child ever received Educational Therapy or Tutoring? No Yes: Please specify:

_____ (_____) _____
Name of service provider Agency Phone number Dates of service

What were the goals of this service? _____

Please provide any assessments completed as part of the above services.

VI. ADDITIONAL INFORMATION

♦ Describe your child's strengths:

♦ What are your child's favorite activities? _____

♦ Describe your child's social relationships, at home and at school:

♦ Please check any of the below that you have observed or that have been brought to your attention by school staff:

- | | | |
|--|--|--|
| <input type="checkbox"/> severe anxiety | <input type="checkbox"/> school refusal | <input type="checkbox"/> isolation |
| <input type="checkbox"/> suicidal statements | <input type="checkbox"/> suicidal actions | <input type="checkbox"/> self-injurious behavior |
| <input type="checkbox"/> physical aggression | <input type="checkbox"/> verbal aggression | <input type="checkbox"/> disruptive in classroom |
| <input type="checkbox"/> profanity | <input type="checkbox"/> provocative to peers | <input type="checkbox"/> stealing |
| <input type="checkbox"/> drug and/or alcohol use | <input type="checkbox"/> sexual comments | <input type="checkbox"/> sexual behavior |
| <input type="checkbox"/> property destruction | <input type="checkbox"/> running away (school or home) | <input type="checkbox"/> hallucinations |
| <input type="checkbox"/> Other: _____ | | |

| For each question identified below, place an X in the box to the right that appropriately describes your child. | Often | Sometimes | Rarely | Never |
|---|-------|-----------|--------|-------|
| 1. My child prefers to do things with others rather than on his/her own. | | | | |
| 2. My child prefers to do things the same way over and over again. | | | | |
| 3. My child has been involved in fights at school. | | | | |
| 4. My child has been suspended from school. | | | | |
| 5. My child finds social situations easy. | | | | |
| 6. When my child talks, it isn't always easy for others to get a word in edgewise. | | | | |
| 7. My child finds it hard to make new friends. | | | | |
| 8. It upsets my child if the daily routine is disturbed. | | | | |
| 9. New situations make my child anxious. | | | | |

♦ Are you aware of or do you suspect any of the following behaviors?

DRUG/ALCOHOL USE:

• Current substance abuse: No Yes: Please specify:

List substances: _____

• Past substance abuse: No Yes: Please specify:

List substances and date of last use _____

• Has your child ever undergone drug treatment? No Yes: Please specify:

Name of program: _____ Dates: _____

Outcome: _____

CRIMINAL/LEGAL INVOLVEMENT:

• Has your child ever been arrested? No Yes: Please specify:

Charge: _____ Date: _____

Outcome: _____

• Is your child currently on probation? No Yes: Please specify:

Date probation ends: _____

• Has your child ever been expelled or asked to leave a school? No Yes: Please specify:

♦ Is there any additional information that you think would be helpful in evaluating your child?

VII. IEP INFORMATION AND FUNDING SOURCE

♦ Does your child currently have Non Public School (NPS) funding?

- Yes: Is the funding through: an IEP
 a mediation agreement

No:

- I have requested due process from the school district
Date of scheduled meeting: _____
 I will pay for tuition and services privately

♦ Are you receiving assistance from an education advocate/consultant or attorney?

- No Yes: Name of advocate: _____

SEEKING PLACEMENT FOR: ___ASAP ___FALL ___SPRING ___SUMMER

VIII. REFERRAL SOURCE

Please provide the following information regarding the person or organization that referred you to The Help Group.

1. _____
NAME

2. _____
NAME

TYPE OF REFERRAL

TYPE OF REFERRAL

AGENCY

AGENCY

STREET ADDRESS

STREET ADDRESS

CITY STATE ZIP

CITY STATE ZIP

PHONE NUMBER

PHONE NUMBER