|  |  |
| --- | --- |
| Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of birth: \_\_\_\_\_\_\_\_\_\_\_ |
| County of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Managed Care Organization (MCO): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**DOCUMENTS TO BE SUBMITTED WITH APPLICATION**

|  |
| --- |
|[ ]  Consent to Exchange Information Form |
|[ ]  Immunization Record |
|[ ]  Cognitive (IQ) Evaluation (within past 3 years) **\*report required\*** |
|[ ]  Academic Achievement Evaluation (within past 3 years) **\*report required\*** |
|[ ]  Autism Spectrum Disorder (ASD) Evaluation (if applicable) **\*report required\*** |
|[ ]  Current Individualized Education Plan (IEP) or 504 Plan (if applicable) **current copy required\*** |
|[ ]  Speech/Language Evaluation (if applicable) |
|[ ]  Neurological Evaluation (if applicable) |
|[ ]  Discharge Summaries from Psychiatric Hospitalizations (if applicable) |
|[ ]  Discharge Summaries from prior residential placements (if applicable) |
|[ ]  DSS reports (if applicable) |
|[ ]  Juvenile Court Records (if applicable) |
|[ ]  Proof of Covid Vaccinations (if applicable)**\*Non-Vaccinated students cannot share bedrooms and we have limited single rooms available.** |

**MANAGED CARE ORGANIZATION (MCO) SIGNATURE OF REVIEW**

MCO submitting referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of submission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MCO Representative Signature of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Care Coordinator (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Wright School Application for Admission**

|  |  |
| --- | --- |
| Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender Identity: [ ] Female [ ] Male [ ] Other (Specify if desired): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Prefer not to answerCounty of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Race: [ ] Black or African-American [ ] White[ ] American Indian or Alaskan Native[ ] Asian[ ] Native Hawaiian and Pacific Islander[ ] Hispanic or Latino or Spanish Origin[ ] Not Hispanic or Latino or Spanish Origin [ ] Prefer not to answer |

 Parent/Guardian Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Phone #(s): | Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 Parent/Guardian(s) Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family members currently living in home with child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Strengths:**  |
| **Interests:**  |
| **Triggers:**  |
| **Academic Skill Deficits:**  |
| **Troubling Behaviors:**  |
| **Diagnoses:**  |
| **Medications:**  |

|  |  |
| --- | --- |
| **Behavioral Strategies/Mental Health Interventions** | **Effectiveness (Describe)** |
|   |   |
|   |   |
|   |   |
|   |   |

**Cognitive (IQ) test:**

|  |  |
| --- | --- |
| Name of test:  | Date administered:  |

|  |
| --- |
| Results:  |

**Answer “YES/NO” for each:**  **If you answered “YES,” describe:**

|  |  |
| --- | --- |
| Allergies: [ ] Yes [ ] No |  |
| Runaway attempts: [ ] Yes [ ] No |  |
| Fire setting: [ ] Yes [ ] No |  |
| Sexualized behaviors:[ ] Yes [ ] No |  |
| Special medical needs: [ ] Yes [ ] No |  |
| Bedwetting: [ ] Yes [ ] No |  |
| History of trauma:[ ] Yes [ ] No |  |
| Autism:Evaluated: [ ] Yes [ ] NoDiagnosed: [ ] Yes [ ] NoSuspected: [ ] Yes [ ] No | \*If evaluated for Autism, the complete evaluation report must be provided with referral\* |
|  Covid Vaccinations Status:Initial : [ ] Yes [ ] NoSecond: [ ] Yes [ ] No Most Current Booster: [ ] Yes [ ] NoNot vaccinated [ ]   | \*If vaccinated for covid, please attach vaccination card. |

|  |  |
| --- | --- |
| Current community school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Grade: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Ever been retained: [ ]  Yes [ ]  No What grade: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

|  |  |  |
| --- | --- | --- |
| Eligible for Special Education services:  | [ ] Yes | [ ] No |

If yes, area(s) of eligibility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, current IEP Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| School Supports and Strategies | Effectiveness (Describe) |
|   |   |
|   |   |
|   |   |
|   |   |

Contact Information:

|  |  |  |
| --- | --- | --- |
| Mental Health Professional | Name |  |
| Agency |  |
| Address |  |
| Work Phone |  |
| Email |   |
| DSS Worker (if applicable) | Name |   |
| Agency |   |
| Address |  |
| Work Phone |  |
| Email |  |
| Guardian Ad Litem (if applicable) | Name |  |
| Agency |  |
| Address |  |
| Work Phone |  |
| Email |  |