The Admissions Process

Residential & Day School

Step 2 Application

Heartspring

Hello again!

We are happy you are exploring enrollment at Heartspring. We hope, at this point, you have a better understanding of our Therapeutic Residential and Day School program and the services we offer.

This packet will provide you with the information we will need to review to better understand your child's strengths, needs, challenges, and your reasons for seeking a placement with Heartspring as well as your expectations for your child's education. Again, if you have any questions along the way, please don't hesitate to contact the Admissions Department at **admissions@heartspring.org**.

1. Complete and return the attached Heartspring Admissions Application.

2. Along with the application, the following documents/records will also need to be submitted, for review:

    - **Educational Documents**
        - Current IEP
        - Initial Special Education Evaluation Placement Report (if available)
        - Any other related services evaluations: such as a speech eval, OT eval, etc.
    - **Psychological/Behavioral Information**
        - Formal psychological evaluation, including full developmental history and IQ testing
        - Functional Behavioral Assessment/Analysis (if one has been completed)
        - Behavior plan(s)
        - Behavior data and/or two to five recent incident reports
    - **Medical Information**
        - Physical exam by a Primary Care Physician (can use the form in the *Heartspring Admissions Application titled "Physician's Page"*)
        - Medication list
        - Additional records from any applicable specialists/providers – or the completed *Medical Information Release(s)* (use the form in the *Heartspring Admissions Application*) so that additional medical records can be requested from applicable providers
    - **Other**
      These are not mandatory for the start of our review process but can be very helpful in determining whether we are able to meet all your child's needs.
        - Short video clips (one to three minutes in length) may be required Situations to include:
            - Academic work (classroom setting, speech or OT therapy session, working on classroom tasks at home, etc.)
            - Mealtime, self-care skills like brushing teeth or putting on shoes, child completing a chore, etc.
            - Interaction between child and a peer or the child and an adult
            - Inappropriate/aggressive behaviors

        - If video clips are not available, we may request a Skype session
    - Prior to enrollment: Proof of guardianship for a child 18 years of age or older.
    - Prior to enrollment: Custodial paperwork if needed/applicable
    - Prior to enrollment: Kansas requires the following immunizations:
        - DTaP (Diphtheria, Tetanus, Pertussis): 5 doses required
        - IPV (Polio): 4 doses
        - MMR (Measles, Mumps, Rubella): 2 doses
        - Varicella (Chickenpox): 2 doses
        - Hepatitis B: 3 doses
        - MCV4 (Meningococcal): 2 doses
        - Recommended: Hepatitis A: 2 doses
    - Prior to enrollment: Kansas Dept. of Health & Environment requires all residential students to have a dental examination completed no more than one year prior to their enrollment. If your child has not had a recent dental examination, you will need to have one completed before enrollment can proceed.

3. The School Leadership Team reviews the application and records. If additional information and records are needed before a decision can be made, the Admissions Department will contact the parents/guardians and/or referring school or agency.

The Heartspring School Serves:

- Students aged 5-22. Ages for openings can fluctuate.
- Students Diagnosed with a Neurodevelopmental Disorder. Most often this is an Autism Spectrum Disorder (ASD) and/or Intellectual/Developmental Disability, but includes other Neurodevelopmental Disorder(s).
- Students with challenging, aggressive, or self-injurious behaviors (exceeding the resources available to the student locally)
- Mild to moderate, non-life-threatening medical conditions such as food/environmental allergies, seizure disorder (with protocols in place and no loss of breathing), gastro-intestinal conditions; minor cardiovascular complications, diabetes, and asthma will also be considered
- Students with communication challenges, who may communicate verbally, or with Augmentative and Alternative Communication including devices and communication books

The Heartspring School Does NOT Serve:

- Students without a Neurodevelopmental Disorder
- Students with a primary diagnosis of a psychiatric condition such as schizophrenia, or a conduct, personality, or bipolar disorder (without a co-occurring DX of a Neurodevelopmental Disorder)
- Students with behaviors such as cutting, or suicidal and homicidal attempts and/or ideations
- Students with a history of using weapons, fire-setting, and/or cruelty to animals
- Students who pre-plan their violent behavior and/or specifically target peers
- Students with sexually deviant/aggressive behaviors

- Students who are medically fragile (G-tubes, CPAPs, ventilators, tracheostomies, or are unable to independently navigate their environment)

4. **Decision Letter**
   A formal decision letter is emailed and/or postal mailed to the parents/guardians and/or referring school or agency.
   - If a denial letter is issued, the letter will include the reason(s) for denial.

5. **Consider a Tour of Heartspring**
   Parents/guardians or the referring school or agency representative are encouraged to contact the Admissions Department to arrange a tour.

6. **Explore Enrollment**
   If an opening is available, an enrollment date will be offered once funding is confirmed. Once an enrollment date has been offered, confirmation will be required within the deadlines outlined in the offer email or letter.
   - If your child is added to the waiting list, it is important to stay in regular contact with the Admissions Department.
   - Enrollments are determined based on available openings in the classroom and residential setting, age of the student, and the best available fit according to the child's strengths, needs, IEP goals, etc.

Admissions Application

Student Information:	
First Name: Middle Name: Last Name:	Date of Birth: ____ /____ /_____ Age:
Gender:	Race: Nationality:
Religion:	Native Language:
Primary diagnosis: Secondary diagnosis: Any additional diagnoses:	

Parent/Guardian/Caregiver Information:
Who is the child's legal guardian? _____
Is this legal guardian (*Circle One):*
Biological Parent, Adoptive Parent, Foster Parent, Other: _____

Please note: While not yet required, <u>prior to enrollment</u> the following will be required. (This is to show proof of decision-making authority):

1) ***If parents/guardians are divorced, a copy of the court custodial paperwork will be required.***
2) ***If a student is 18 years of age or older, legal conservatorship/guardianship paperwork will be required.***

Mother/Guardian			
First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Cell Phone:		
Email:			
Employer:	Occupation:		
Work Phone:			

Father/Guardian			
First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Cell Phone:		
Email:			
Employer:	Occupation:		
Work Phone:			

Where is the child currently living? _____

List all current (and past) schools and placements. *(Please include: public, private, special day school, residential placement, group home, etc.)*

Elementary School		
Dates	**School/Program Name**	**Type (public, residential, etc.)**

Middle School		
Dates	**School/Program Name**	**Type (public, residential, etc.)**

High School / Secondary School		
Dates	**School/Program Name**	**Type (public, residential, etc.)**

Family Information:

Student's Siblings			
Name	**Age**	**Grade in School**	**Health Concerns (if any)**

What are the main concerns causing you to explore residential placement?

_____

_____

How did you hear about Heartspring?

_____

Behavior Concerns: Mark any behaviors your child currently exhibits.

□ Aggression towards others □ Self-injurious behaviors □ Property destruction □ Non-compliance □ Eloping □ Mouths objects (but doesn't swallow them) □ PICA (swallows objects)	□ Dropping □ Temper tantrums (screaming, yelling, crying) □ Loud vocalizations □ Strips/removes clothing □ Toileting behaviors (urinates in inappropriate places and/or smears feces)

□ Sexually inappropriate behaviors towards self (ex: public masturbation, touching self in/out of pants, etc.) **Please explain:**

□ Sexually inappropriate behaviors towards others. **Please explain**:
Other behaviors or explanations about above behaviors:
Triggers observed to provoke the above stated behaviors:

Past behaviors (please note month/year of last occurrence):
Protective equipment used due to behavioral concerns: (ex: helmet, padded desk, seatbelt harness, etc.)

Does your child have behavioral problems when:

____ Your child is in large groups
____ Your child is in small groups
____ Your child is alone
____ Your child is given a difficult task to perform
____ Your child hears sudden or loud noises
____ When told "no" or a preferred item is taken away

Has your child experienced any past trauma or witnessed any traumatic events?

Examples may include:

- Physical abuse
- Verbal/Emotional abuse
- Sexual abuse
- Death/abandonment of a family member or caregiver
- Police involvement
- Physical restraint(s) that caused physical injury
- Numerous medical procedures or hospitalizations
- Natural disaster

If so, please describe:

_____

_____

_____

We may require additional phone consultations to ensure we have a full picture of any past trauma.

You may also request to disclose this information verbally, either over the phone or in person. If so, please check this box:

□ I would like to schedule a phone consultation/meeting to discuss my child's past trauma.

What interventions, programs, services, etc. have been tried to reduce the problem behavior(s)? (Include all, even if not listed in the IEP)

Functional Self-Help Skills:	Yes	No	Comments
Is the child RIGHT or LEFT handed?			
Eats all textures of foods			
Uses spoon to scoop food			
Uses fork to pierce food			
Uses knife and fork to cut food			
Gets food to mouth			
Chews food			
Swallows food			
Drinks from a cup or glass			
Drinks from a straw			
Shaves (razor, electric, etc.)			
Brushes teeth thoroughly (manual or electric brush?)			
Brushes or combs hair			
Washes hands thoroughly			
Bathes all body parts			
Dresses self			
Undresses self			
Puts on shoes			
Takes off shoes			
Ties shoelaces			
Manages zippers			
Manages buttons			
Assists with household tasks			
Toilets independently			
Is toilet scheduled			
Pulls clothing up and down			
When toileting - Wipes thoroughly			
Adaptive Equipment (adapted eating utensils, visual supports, etc.)			

Functional Mobility:	Yes	No	Comments
Gets on and off toilet			
Gets in and out of car			
Gets in and out of bed			
Gets in and out of shower or tub			
Walks without support			
Runs without support			
Open and closes doors			
Manages up and down curbs			
Walks up/down full flight of stairs			
Past/Current Adaptive Equipment (Ex: walker, orthotics, etc.)			

Functional Communication:	Yes	No	Comments
Uses sign language			
Uses gestures			
Points to communicate			
Uses eye gaze			
Communicates in single words			
Communicates in word phrases			
Cries or whines to communicate			
Uses written communication (writes or types)			
Uses own jargon			
Follows verbal directions			
One step			
Two Step			
Three Step			
Past/Current Adaptive Equipment (Ex: PECS book, voice output device, pictures, etc.)			

Strengths/Recreation/Leisure:

What are your child's strengths?

_____

What are your child's interests/likes:

_____

What objects, foods, or activities are positive reinforcers for your child?

_____

_____

Has your child received any school evaluations or consultation reports from:
(Please provide copies of evaluations.)

School Psychological Evaluation – Date: _____

Functional Behavioral Assessment – Date: _____

Speech-Language Evaluation – Date: _____

Occupational Therapy Evaluation – Date: _____

Physical Therapy Evaluation – Date: _____

Medical Information

Past Medical History of Child:
List any complications with pregnancy, labor, or delivery:

_____

_____

Mother's age at delivery: _____ Number of previous pregnancies: _____

Number of weeks of gestation at time of delivery: ____ Mode of delivery: _____

Child's birth weight: _____ Child's birth length: _____

How long did your child stay in the hospital after birth? _____

Were there any problems immediately following birth? _____

Was there any use of prescription medication, drugs, alcohol, or tobacco by the mother during pregnancy? If known, please list:

_____

Were there any significant childhood diseases or serious illnesses? **Y / N**

If yes, explain:

_____

_____

Past Developmental History: At what age did your child do the following?

Crawl: ___

Walk independently: _____ Feed him/herself: _____

Dress him/herself: _____ Start using words: _____

Putting sentences together: _____ Toilet training: _____

Physical Health History/Concerns:	Yes	No	Comments
Headaches			
Head trauma			
Psychosis/hallucinations			If yes, please describe:
Frequent nausea/vomiting			
Eye or vision problems (wears glasses/contacts?)			

Hearing or ear problems (wears hearing aids?)			
Reoccurring ear infections			
Reoccurring colds/sore throats			
Skin conditions (rashes, eczema, etc.)			
Constipation			
Diarrhea			
Toileting accidents (frequency)			
Dental problems			
Seizures (list type, frequency, etc.)			
Fainting spells			
Heart deformities			
Abnormal blood pressure			
Asthma or breathing problems			
Chewing problems			
Swallowing problems			
Trouble falling asleep			
Trouble staying asleep			
Other sleeping problems (or needs less than 4-5 hours of sleep?)			
Neuromuscular concerns (explain, and also list areas of the body affected)			
Other medical complications			If yes, please list:

Current Height: _____ Current Weight: _____

Allergies: Please check any of the following and explain.

__ Medication Allergies/Reactions: _____

__ Food Allergies: _____

__ Seasonal Allergies: _____

__ Takes ongoing (or as-needed) medication for allergies: _____

Family Medical History: List any of the following that have been experienced by members of the child's family. Please identify which family member.

(Ex: parent, grandparent, aunt, siblings, cousins, etc.)

Intellectual / Developmental Disabilities

Who: _____

Learning Disabilities

Who: _____

Mental Illness

Who: _____

Seizures

Who: _____

Headaches Migraines

Who: _____

Diabetes

Who: _____

Multiple Sclerosis

Who: _____

Visual Impairments

Who: _____

Hearing Impairments

Who: _____

Nerve / Muscle Problems

Who: _____

High Blood Pressure

Who: _____

Heart / Cardiovascular Problems

Who: _____

Other: _____

Who: _____

List all past hospitalizations (medical and/or psychiatric):

Date or Age	Name of Hospital	Reason

List all surgical procedures (out-patient and/or in-patient):

Date or Age	Name of Hospital	Reason

Please provide your child's last:

Hearing evaluation: Date _____ Results: _____

Vision Screening: Date _____ Results: _____

Dental exam: Date _____ Was sedation required? _____

(Please note: KS requires all students to have a current (within 12 months) dental exam on file).

Has your child ever had any of the following diagnostic procedures?

Procedure:	Yes	No	Comments (Please provide date and primary results.)
EEG (brain wave)			
CT Scan			
MRI Scan			
High Resolution Chromosome Testing			
Fragile X Testing			
Chromosomal Microarray			
Other diagnostic tests/procedures			

Current Medications: You may attach a list from your doctor or pharmacy.

Medication	Dosage	Reason Prescribed

Past Medications: Provide a complete list of PAST medications & reasons for discontinuing. You may attach a list from your doctor or pharmacy.

Medication	Date/Age Used	Reason Prescribed	Reason Discontinued

How does your child take his/her medication(s)?

□ Swallows with drink - Explain: _____

□ Crushed in food/drink - Explain: _____

□ Liquid medications only - Explain: _____

□ Other - Explain: _____

Current supplements, alternative medical treatments, special diets, etc.: Please note, without supporting scientific validation/medical documentation, these may not be continued at Heartspring. (Please refer to Heartspring's Evidenced Based Practices Policy).

Supplement / Treatment / Special Diet	Date/Age Used	Reason for Use	Reason Discontinued	Doctor Ordered? (Y / N)

Please list your child's age below, if applicable:

Received a developmental/intellectual disability diagnosis? _____;

Physician who made the diagnosis: _____; Current IQ: _____

First received early intervention? _____

Began receiving special education services? _____

What diagnosis was received? *(Circle all that apply and indicate age at time of diagnosis).*

Autism Spectrum Disorder – Age: _____; Physician who made the diagnosis: _____

ADHD – Age: _____

Depression – Age: _____

OCD – Age: _____

Bi-Polar – Age: _____

Anxiety – Age: _____

Seizures – Age: _____

ODD – Age: _____

Mood Disorder – Age: _____

Other diagnosis: (please list)

_____

_____

_____

Current/Past Physicians: (Please include a signed "Authorization for the Release of Patient Health Information" (found within this application) for each listed physician/clinic/hospital. Please make copies of this release form as needed).

Physician / Professional	NAME of Physician/Professional *and/or* the Clinic/Hospital	Dates Seen	Release Form Attached (ü)
Current Developmental Pediatrician			
Past Developmental Pediatrician(s)			
Current Family Physician			
Past Family Physician(s)			
Current Neurologist			
Past Neurologists(s)			
Current Psychiatrist			
Past Psychiatrist(s)			
Current Psychologist			
Past Psychologist(s)			
Current Dentist			
Past Dentist(s)			
Other Specialist (Gastroenterologist,			

ENT, cardiologist, etc.)			

_____

(Signature of Person Filling out the Application)

_____

(Printed Name)

_____

(Date)

Admissions Policy Statement:
Heartspring subscribes to and supports all laws concerning non-discrimination and special education services. It is the policy of Heartspring to provide client services to all persons without regard to race, color, sex, religion, national origin, ancestry, disability, marital status, and age, except that disability and/or age are bona fide admissions considerations. This policy includes, but is not limited to, evaluation, enrollment, change of service, and termination.

Heartspring School | Wichita, KS
800-835-1043 | Fax: 316-634-8875 | admissions@heartspring.org | www.heartspring.org

Heartspring

Physician Assessment

This assessment is to be performed by a licensed physician, physician's assistant, or nurse approved to perform health assessments.

Child's Name: _____ **DOB:** _____

Diagnosis: _____

Physical Examination: Height: _____ Weight: _____ **Allergies**: _____

Current Medications: *(including doses and frequency)* _____

_____

Nutritional Status: _____ **Prescribed Special Diet:** _____

For the following, record POSITIVE findings only:

Head: _____ Teeth: _____ Lungs: _____
Abdomen: _____ Gyn: _____ Neurological: _____
EENT: _____ Heart: _____
GU: _____ Skeletal: _____

Screening Tests: For the following, please list date and completed results (if available, attach copies of results):
Vision: _____ Hearing: _____ Dental: _____

Lab results: CBC: _____ CMP: _____ TSH: _____ RPR: _____ Hep panel: _____ UA: _____

Past Health History: (Please describe developmental disability or attach a dictated summary).

_____

_____

Recommendations:

_____

_____

Do you see this child for regular health supervision? YES / NO **Date of Last Visit:** _____
Immunization Information: (Circle YES or NO. Explain if applicable). *(Include immunization records).*

Are immunizations up to date? **YES / NO** If no, explain: _____

Were there any reactions to immunizations? **YES / NO** If yes, explain: _____

_____ _____
(Physician Signature) (Date)

_____ _____
(Print Name) (Subspecialty)

FAX this form (including immunization records) to: Dr. Valarie Kerschen C/O Admissions at 316-634-8875

Heartspring

Authorization for the Release of Patient Health Information

Patient Information

Patient Name _____

Date of Birth _____

Address _____

City / State / ZIP _____

Telephone # _____

I hereby authorize the release of Protected Health Information for the above-named patient to be released from/to:

From:
Person/Institution _____
Specialty _____
Address _____
City/State/ZIP _____
Telephone _____
Fax _____

To:
Heartspring, Inc. / Dr. Valarie Kerschen
8700 East 29th Street North
Wichita, KS 67226
Telephone: 316-634-8700
Fax: 316-634-8875

I authorize the release of information covering the period(s) of healthcare between:

Start date _____
End date _____
OR
□ All dates of service

The type(s) of information requested are (please check all):

□ Abstract (health summary)
□ Consultation Reports
□ Progress Reports
□ Immunization Record
□ Medication History
□ MRI/EEG/EKG Procedures
□ History & Physical Exams
□ Operative Reports
□ X-Ray Images
□ Vision Screenings
□ Psychological Evaluations
□ Audiology Reports
□ Discharge Summaries
□ Diagnostic Reports
□ Emergency Record
□ Dental Screening
□ **Hospitalizations**

Authorization for the Release of Patient Health Information

Patient Name _____ Date of Birth _____

The following highly confidential information is to also be included:

□ Genetic Testing Information	□ Birth Control	□ Behavioral/Mental Health

This information will be used for the following purpose: Continuance of Care with new medical provider
This release will expire one (1) year from the date of signature below.

_____ _____
Signature of Patient Over 12 Years of Age Date

□ If this box is checked, the patient is incapable of signing for his/herself to authorize the release of PHI, due to a diagnosis of developmental delay. The parental/legal guardian below has the authority to sign for the patient.

_____ _____
Printed Name of Parent/Legal Guardian Relationship to Patient

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Witness (REQUIRED) Date

Personal Information/Records Release

_____ _____
(Student Name) (Date of Birth)

I HEREBY GIVE MY PERMISSION FOR WRITTEN AND VERBAL INFORMATION TO BE SHARED:
YES **NO**

I HEREBY GIVE MY PERMISSION FOR HEARTSPRING TEAM MEMBERS TO OBSERVE, VIDEO, AND/OR RECEIVE VIDEO FROM THIS PROFESSIONAL / ORGANIZATION:
YES **NO**

RELEASED TO:
Heartspring School
8700 East 29th Street North
Wichita, KS 67226
316-634-8700

RELEASED FROM:

_____
(Professional / Organization Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone Number)

_____
(Fax Number)

Records To Be Shared Include Any and/or All of the Following:

- IEP's
- Immunization Records
- Vision Screenings/Reports
- Dental Screenings/Reports
- Audiology Reports
- Admit & Discharge Reports
- Behavior Plan/Data
- Psychological Evaluations
- Evaluation Summaries
- Educational Reports
- Occupational Therapy Reports
- Speech Language Reports
- Other, as appropriate

_____ _____
(Parent/Patient or Legal Guardian) (Date)

REASON**:** CONTINUITY OF CARE. This form shall expire 1 year from the original date signed. The client has the right to revoke this request at any time. By signing this authorization, you acknowledge and agree that any information used or disclosed could be at risk for redisclosure by the recipient and no longer protected by HIPPA laws. Heartspring policy is not to release to/or received by third party. I understand that Heartspring may directly or indirectly receive remuneration from a third party in connections with the use and disclosure of my health information.

Next Steps

☑

Step 1

Inquiry Phase

☑

Step 2 – CURRENT PHASE

Submit Application
Provide Records
Tour our Campus (may do this in Step 1 if preferred)
Acceptance Letter
Enrollment Date Offer

☐

Step 3

Admissions Process Continues
Tour Our Campus (if not already completed in Step 1 or 2)
Enrollment Date