PATHWAYS
Adult Learning Center

918.859.0060
www.pathwaysok.com
P.O. Box 703064 Tulsa, OK 74170-3064

Application for Enrollment

***The following information is confidential. Pathways Adult Learning Center will not disclose information to any third party or make use of information for purposes not related to the acceptance of this applicant into Pathways Adult Learning Center.**

Mission Statement: Pathways provides a unique Christian Program dedicated to enhancing the quality of life for adults with intellectual disabilities by assisting each individual to achieve emotional, cognitive, physical, social, spiritual and vocational growth to his/her fullest potential.

This application is the first step in determining the eligibility of each applicant for Pathways Adult Learning Center. Please complete this application as thoroughly as possible and return to:

Kirk of the Hills
Attention: Pathways Adult Learning Center
4102 E 61st St.
Tulsa, OK 74136

GENERAL INFORMATION

_____ _____ _____

Applicant's Full Name **Applicant's Preferred name** **Date**

_____

Street Address **City** **State** **Zip**

(___) _____

Telephone No. **Birthday DD/MM/YYYY**

Is the applicant his/her own legal guardian? Yes No If no:

Name of Financial Legal Guardian: _____ Address:_____
Relationship to the applicant: _____ Phone:_____
Email:_____ Do you check your email regularly?_____

Name of Personal Legal Guardian: _____ Address: _____
Relationship to the applicant: _____ Phone:_____
Email:_____ Do you check your email regularly?_____

Person applicant resides with:
Name: _____ Relationship to Applicant: _____ Phone: _____

Other support systems:

Name: _____ Relationship to Applicant: _____
Phone: _____ Address: _____

Name: _____ Relationship to Applicant: _____
Phone: _____ Address: _____

Name: _____ Relationship to Applicant: _____
Phone: _____ Address: _____

Please list two individuals other than the legal guardian who have known the individual well for at least a year and can serve as references. *Non-family member reference.

Individual #1:

_____
Name

_____
Phone Relationship to Applicant

Individual #2:

_____
Name

_____
Phone Relationship to Applicant

Is the applicant able to stay home alone? **Yes No**
In a group setting, would the applicant require one-on-one care? **Yes No**
If yes, explain:
_____
_____

Pathways will not be able to provide one-on-one care for students. If it is determined by Pathways that this applicant needs one-on-one care, the applicant will be not be accepted into Pathways at this time.

FINANCIAL INFORMATION

***Tuition is $5.00 an hour and is due on the 1st of every month.**

(Scholarship funds are available on a limited basis. If financial assistance is required, please indicate on this application.)
Would you like to apply for a scholarship application from Pathways? **Yes No**

Person responsible for the financial commitment: Name: _____
Address: _____ Phone: _____ E-mail: _____

EXPERIENCES

Did the applicant attend high school? **Yes No**
If yes, grade last completed: _____ Name of school: _____
Year last attended: _____

Check all situations in which the applicant has participated, and complete the following information on each situation. (Please use the back of this page if more space is needed.)

____ Day School
____ Sheltered Workshop
____ Group/Family Care Home
____ Independent Living Situation
____ State School
____ Private School
____ Employment
____ Volunteer
____ Kirk Programs
____ Other, explain: _____

Name of school/facility/center Dates: _____
Address: _____
Type of Situation (Refer to above list) _____
Reason for leaving _____
Person to contact for more information: Name: _____ Phone: _____

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Address: _____
Type of Situation (Refer to above list) _____
Reason for leaving _____
Person to contact for more information: Name: _____ Phone: _____

Please answer the following questions:

1. List the names of disabilities that have been diagnosed:
   _____

2. Please describe the applicant's disability and indicate the challenges and issues facing the applicant as a result of this disability? _____
   _____
   _____

3. Please describe the applicant's general heath, and indicate any significant medical concerns in which Pathways should be advised to enable Pathways to maintain the safety and protection of the applicant _____
   _____
   _____
   _____

4. Please describe any behaviors that Pathways should be aware of and the most effective response to these behaviors.
   _____
   _____
   _____
   _____

5. Please circle how the applicant gets around? 1. Walks 2. Wheelchair 3. Motorized Wheelchair 4. Walker

6. Does the applicant need assistance getting around? **Yes** **No**
   If yes, explain: _____
   _____

7. Is the applicant: (Please circle)

Predominantly non-verbal Somewhat verbal Predominantly verbal

8. How does the applicant communicate? (Please circle)

Verbal Sign Language W/Electronics Other (please explain): _____

8. Does the applicant read? **Yes** **No**
If yes, what level is he/she on? _____
Please indicate any assistance needed for reading: _____

9. Please describe applicant's personality? _____
_____
_____

10. What assistance does the applicant need on a daily basis? _____
_____
_____

11. Please describe applicant's daily routine and leisure activities. _____
_____
_____
_____

12. Please describe activities, areas, and/or situations that the applicant strongly dislikes or fears. _____
_____
_____

13. Please describe the applicant's strengths: _____
_____
_____

14. Please describe your goals and expectations for the applicant in this program. _____
_____
_____
_____

15. If applicant is accepted into the program describe how Pathways will be able to benefit the applicant and the family.
_____
_____
_____
_____

Answer the following questions by circling Yes or No:

YES NO Pathways is a Christian program that pours the love of Christ into our students daily through prayer, Bible studies, and choir. Are you comfortable with that environment?

YES NO Has the applicant used illegal drugs in the past three years?
If yes, has the applicant been to treatment and what was the outcome of the treatment?

_____

YES NO Has the applicant ever been treated for alcoholism?
If yes, identify the dates of treatment, the outcome of the treatment and whether the applicant has consumed alcohol since receiving treatment:

_____

YES NO Has the applicant ever been hospitalized for mental health reasons?
If **YES**, what is the date of most recent hospitalization? _____
What was the reason for the most recent hospitalization? _____
Was the applicant successfully discharged? _____
How many times has the applicant been hospitalized for this reason? _____

YES NO Has the applicant ever been physically abusive to self?
If **YES**, describe the abusive behavior and date of the last incident.

_____

YES NO Is the applicant physically aggressive?
If **YES**, describe the behavior:

_____

YES NO Is the applicant verbally aggressive? If yes, describe the behavior.

_____

YES NO Has the applicant ever been charged with a misdemeanor or felony?
If **YES**, identify the formal charge and the date of the alleged offense:

_____

YES NO Has the applicant ever engaged in sexual misconduct?
If yes, please describe the activity and the date of the activity:

_____

YES NO Does the applicant participate in self-stimulatory behaviors?
If **YES**, please indicate the frequency of the behavior.

_____

YES NO Does the applicant tend to wander off?

YES **NO** Does the applicant put random items in his/her mouth?

YES **NO** Does the applicant frequently choke?

YES **NO** Does the applicant need assistance in the restroom? If yes, please describe the assistance needed.

YES **NO** Does the applicant wear pull-ups or depends?

YES **NO** Does the applicant have sensory issues?

YES **NO** Does the applicant have a driver's license?
YES **NO** If yes, does the applicant currently drive?

DIETARY

List any food restrictions or food allergies: _____
_____

Can the applicant drink from a glass? _____ If no, explain: _____
_____

Does the applicant require supervision/assistance while eating? _____ If yes please explain: _____
_____
_____

Does the applicant require specialized equipment or positioning for eating? _____ If yes, please explain: _____
_____
_____

List any food restrictions or allergies: _____
_____
_____

HEALTH HISTORY

If the applicant is prone to (or has had) problems with any of the following, please indicate. If YES, please circle and explain.

Cold/Sinus_____ Headaches_____ Eyes_____

Ears _____ Chest _____ Asthma_____

Epilepsy _____ Tuberculosis_____ Heart_____

Kidney _____ Stomach _____ Diabetes_____

Diarrhea _____ Constipation_____ Fainting Spell_____

Menstrual Cycle_____ Muscles _____ Neurological_____

Please list and explain other health concerns not listed above:

_____
_____
_____
_____

List surgeries or hospitalizations in the last two years:

_____
_____
_____
_____

Is applicant on any regular medications? **Yes** **No**
If yes, please list below:
(If more space is needed, use separate piece of paper and attach) Name Dosage/Frequency

_____
_____
_____
_____

Please list any medical allergies the applicant has:

_____
_____
_____

***IMPORTANT**
If there are other facts or anything that you know of that is not listed which would be a factor and could influence the care, health, and well-being of this applicant at Pathways, please explain.

_____
_____
_____

PATHWAYS PROGRAM SELECTION

Pathways has program options from 8:30 a.m. to 5:00 p.m. Monday-Friday. Please indicate whether you are interested in a full-time or a part-time program. (Please circle one)

Full Time **Part Time**

Would you be interested in before care? (8:30 a.m. to 9:00 a.m.) **$25 additional fee a month* **Yes** **No**

If yes, please describe your needs:_____
_____

Please make sure that the application is complete and read the statement below and sign.

I affirm that the preceding information is a complete and true statement of all the facts, circumstances, and medical information relative to this student's application for enrollment in Pathways.
We, the undersigned, do give our permission for Pathways to contact any or all of the references, programs, schools, and professionals listed on this application.

_____	_____	_____	_____
Signature of Applicant	Date	Signature of Legal Guardian if not Applicant	Date
_____	_____	_____	_____
Signature of Member of Support System	Date	Signature of Member of Support System	Date