Moving Forward
Towards Independence

Moving Forward Application Procedure

Thank you for your interest in Moving Forward. The following documents are required for your admissions file. Upon completion of application materials, you will be contacted to set up a trial visit assessment. This assessment is considered part of the application process.

REQUIRED DOCUMENTS	Completed ✔	Date Sent ✔
Application: To be completed by a parent/guardian and sent in with a $200.00 application fee.		
Educational Information: High School/Post Secondary Records/ Most recent IEP.		
Medical Information: A medical form to be filled out by a parent/guardian. A medical form to be completed and signed by the applicant's Physician.		
Intellectual Assessments and Psychological Reports: Reports must be within a three-year period. If not, the applicant must be reassessed in order to have a complete application. The test battery must include the following: an adult measure of intelligence (i.e. WAIS III-R or WISC-III depending on the age of the applicant), an achievement measure (i.e., KABC, WIAT-2, or Woodcock Johnson), a personality/projective measure (i.e., Rorschach, Thematic Apperception Test, or MMPI-2) and a behavior measure (i.e. Conner's, Vineland, or BASC). In addition to the psychological report, a consent for release of information must be signed by the applicant.		
Physical Exam: A recent (within the year) physical exam must be performed by the applicant's physician as part of the application process, including a TB Test within one year of this application.		
Forms from professionals who have worked with the applicant: To be completed by: 1. An educator/educational specialist. 2. A psychologist or counselor. 3. An employer, supervisor, job coach or Department of Rehabilitation Counselor, if applicable. 4. A social worker, program specialist, or case manager.		

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Patient's Name

Last First Middle Birth date

Parent's/Conservator authorization: I hereby give my consent to Moving Forward to receive from or send to Dr._____ any information concerning my child.

Signature

Address

Phone Number Date

Vaccines

Date each dose was given	**1st**	**2nd**	**3rd**	**4th**	**5th**
Polio (OPV or IPV)	/ /	/ /	/ /	/ /	/ /
DTP and/or DT/Td	/ /	/ /	/ /	/ /	/ /
Measles (Rubella- 10 day, red measles)	/ /	/ /			
Rubella (German measles- 3 day measles)	/ /	/ /			
Mumps	/ /	/ /			

Tuberculosis Assessment Required In Some Jurisdictions ~ Check With Your Local Health Department

TB Skin Test *(List most recent test and result)*	Date Given	Mm indur	Impression
	/ /	mm	pos neg
	/ /	mm	pos neg

Chest X-Ray *(Required if skin test is positive)* Film Date: / /

Impression: ❍ Normal ❍ Abnormal

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Moving Forward is a comprehensive, residential program providing independent living, academic and vocational skills training. With this in mind, please answer the following questions regarding the above mentioned patient.

1. Does the patient have asthma, eczema or other allergies?

2. Are there any health problems which would limit his/her participation in:
   - ❍ Courses taken at the local community college?
   - ❍ Physical education, including any sports, aerobic or weight training activities?
   - ❍ Utilization of public transportation?

Does the patient have any physical limitations or restrictions which would impact his/her participation in a vocational training and job placement program? If so, please describe.

3. Is there any emotional, mental, or physical condition which Moving Forward should be aware of, e.g. seizure disorder, fainting, diabetes, heart disease, etc.?

4. Does the patient take any medication? If so, what are they, for what are they prescribed, how much and how often are they administered? Symptom/Indication and Medication Administration.

Does the patient take medications on his/her own? ❍ Yes ❍ No

5. Other comments or recommendations:

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How long has the patient been under your care?

Date of Examination: _____

Examining Physical Signature | Date

Print name

Street | City | State | Zip

Phone Number

Please return this form to:

Moving Forward Towards Independence
Sirena Domecus
68 Coombs Street, Bldg. B
Napa, CA 94559

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MOVING FORWARD TOWARDS INDEPENDENCE CONSENT FOR RELEASE OF INFORMATION

(To Be Signed By Applicant)

My signature below will constitute my consent for the release of pertinent educational, medical, and/or psychological information *to and from* Moving Forward Towards Independence while I am enrolled in this program.

These individuals include the following *(Please include telephone numbers)*:

I understand that the records and information released will be kept CONFIDENTIAL.

Date Client Signature

Mailing Address

Telephone

Parent/Conservator Signature

Moving Forward Towards Independence
Sirena Domecus
68 Coombs Street, Bldg. B
Napa, CA 94559

(707) 259-1125 / FAX (707) 244-2082

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MEDICAL/DENTAL INFORMATION

Name

Parent's Names

Parent's Address

Parent's Phone

Medical Insurance Company Information

Medical Insurance

Address

Phone Number Medical Ins. #

Physician Information

Doctor's Name

Address

Phone Number

Does your insurance carrier require that your son/daughter seek medical care from a predetermined physician, group of physicians, or hospital? If so, who is the physician and hospital required to be seen in Napa? If not, do you have a physician in mind in Napa?

Current Medications

Symptom/Disorder	Medication	Dosage

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MEDICAL/DENTAL INFORMATION

Dental Insurance Company Information

Dental Insurance Company

Address

Phone Number

Dental Insurance #

Dentist Information

Dentist's Name

Address

Phone Number

Does your insurance carrier require dental care be sought from a predetermined dentist or group of dentists? If so, who is the dentist required to be seen in Napa? If not, do you have a dentist in mind in Napa that you would like for your son/daughter?

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MEDICAL/DENTAL INFORMATION

Emergency Contacts

In case of an emergency and you cannot be reached, please list two other people whom we should contact.

Name | Relationship

Phone Number

Name | Relationship

Phone Number

In case of an emergency and no family members or other persons listed above can be reached the staff of Moving Forward have permission to approve medical and/or dental treatment as necessary for:

Signature | Date

Print Name | Relationship

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MOVING FORWARD APPLICATION ~ APPLICANT INFORMATION

Applicant

First Name | Middle | Last

Address

City | State | Zip

Phone Number | Social Security Number

Date of Birth | Gender: ❍ Male ❍ Female

Desired Entrance Date: _____

Who referred you to our program? _____

Legal guardian/Conservator (if any): _____

Is the applicant a U.S. Citizen? ❍ Yes ❍ No

If no, what is the country of citizenship? _____

Has the applicant ever been arrested? _____

Has the applicant ever used drugs or alcohol? Please explain.

Does the applicant have a history of physical and/or sexual abuse? _____

Does the applicant have difficulty understanding personal boundaries? ❍ Yes ❍ No
If yes, please explain.

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MOVING FORWARD APPLICATION ~ PARENT/GUARDIAN INFORMATION

Parent/Guardian

Parent's Name / Step Parent	Parent's Name / Step Parent
Address	Address
Home Phone Number	Home Phone Number
Email	Email
Work Phone Number	Work Phone Number
Employer	Employer
Job title	Job title

Family History

Does anyone in the applicant's family have a learning problem? ❍ Yes ❍ No
If yes, please describe: _____

Does anyone in the applicant's family have any other type of disability
(e.g., physical, emotional, vision or hearing impairment)? ❍ Yes ❍ No
If yes, please describe: _____

Please provide the names and ages of the applicant's siblings: _____

Which siblings live at home? Which do not? _____

Please describe the applicant's relationship with his/her siblings: _____

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MOVING FORWARD APPLICATION ~ HEALTH INFORMATION

Health Information

Does the applicant have vision problems? If yes, please describe. _____

_____

Has the applicant had problems with hearing? If yes, please describe.

_____

_____

Does the applicant have allergies or asthma? _____

Does the applicant smoke cigarettes? _____

Is the applicant on any medications at the present time? ❍ Yes ❍ No
If yes, please identify:

a) Name(s) of medication(s) _____

b) Dosage _____

c) For what condition(s) _____

d) Side Effects _____

Does the applicant take medications on his/her own? _____

Does the applicant have any health issues that would interfere with utilizing public transportation?

_____

Does the applicant have any health issues that would interfere with physical education or physical exercise?

_____

_____

Has the applicant had any behavior problems at home, or had any sleep or eating disorders? If yes, please explain.

_____

_____

_____

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MOVING FORWARD APPLICATION ~ SCHOOLS/PROGRAMS ATTENDED

School/Program, Address, Dates of Attendance *(Please list most recent first):*

1. _____

2. _____

3. _____

Please describe the applicant's academic strengths, weaknesses and special areas of interest:

Please describe the applicant's learning style, including how he/she approaches tasks, deals with frustration and compensates for learning differences:

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MOVING FORWARD APPLICATION ~ SCHOOLS/PROGRAMS ATTENDED

Student Profile

Has the applicant ever lived away from home? If so, please describe any anticipated living adjustment difficulties:

What are the applicant's responsibilities at home? (i.e., helping with chores):

Does the applicant manage his/her own money? Please describe.

Does the applicant manage/administer their own medication? Please describe.

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MOVING FORWARD APPLICATION ~ WORK HISTORY

Work History

Is the applicant a client of the Department of Vocational Rehabilitation? ❍ Yes ❍ No

Are they currently employed? If yes, please describe current employment:

Please describe any previous jobs, length of employment and job duties below.
Job Title, Company, Dates of Employment, Reason for Leaving

1.

2.

3.

Transportation

Does the applicant have a driver's license? Permit?

Will the applicant have a vehicle while enrolled at MFTI?

Is the applicant able to take public transportation? Airplanes? Trains?

What is the farthest distance the applicant has gone on his/her own?

How does the applicant spend his/her time (Hobbies, Activities, etc.)?

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MOVING FORWARD APPLICATION ~ WORK HISTORY

Professionals who have worked with the applicant

Recommendation letters to be sent to Moving Forward from the following professionals:

Case Manager/Program Support Person/Social Worker Recommendations:

Name Title

Address

Educator Recommendation:

Name Title

Address

Employer/Supervisor Recommendation:

Name Title

Address

Psychologist/Therapist Recommendation:

Name Title

Address

Signature

Parent/Conservator Date

Parent/Conservator Date

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MOVING FORWARD APPLICATION ~ RECOMMENDATION FORM

_____ has applied for admission to Moving Forward, a comprehensive post secondary program for young adults with learning differences located in Napa, California. This exciting program offers independent living skill straining, educational opportunities through the local community college, vocational training and job placement, and social/recreational opportunities. Young adults accepted into the program must have as a realistic goal in their lives to live and work independently.

With this in mind, please answer the following questions to the best of your ability. Please use the additional pages if more writing space is needed. All recommendations are strictly confidential.

Please return this recommendation form to:

Moving Forward Towards Independence
Sirena Domecus
68 Coombs Street, Bldg. B
Napa, CA 94559

Your Name _____ Title _____

Organization _____ Phone _____

Address _____

How long have you known the applicant, and in what capacity?

Are there any limitations that may prevent this applicant from fully benefiting from our program?

In your opinion, are there any physical limitations that would prevent this applicant from successfully achieving his/hers goals?

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MOVING FORWARD APPLICATION ~ RECOMMENDATION FORM

Is it your opinion that the parents/guardians of the applicant will support the efforts of the Moving Forward program and the applicant's goals towards greater independence?

Describe the applicant's strengths and areas of interest:

Describe the applicant's weaknesses and areas of challenge:

How does the applicant compensate for personal learning differences?

How does the applicant deal with stress/frustration/anger?

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MOVING FORWARD APPLICATION ~ RECOMMENDATION FORM

Educators Only

Please describe the applicant's academic strengths and weaknesses:

Please describe the applicant's learning style, including how he/she approaches new tasks:

Employers Only

Please describe the job performed by the applicant, the setting, and the level of independence/responsibility the applicant had in the position:

What were the applicant's strengths and weaknesses?

Is this type of work a realistic goal for the applicant?

If no, do you have recommendations for future career goals for the applicant?

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MOVING FORWARD APPLICATION ~ RECOMMENDATION FORM

Please rate the applicant on the following characteristics on a scale of 1 to 5.
1: serious deficit / **2:** frequent difficulty / **3:** moderate difficulty / **4:** slight difficulty / **5:** no difficulty
Circle the rating in the appropriate categories.

Initiative	1	2	3	4	5
Motivation	1	2	3	4	5
Reliability	1	2	3	4	5
Perseverance	1	2	3	4	5
Ability to cope with stress/frustration	1	2	3	4	5
Ability to build and maintain friendships	1	2	3	4	5
Ability to adjust to new situations	1	2	3	4	5
Ability to act appropriately in an emergency	1	2	3	4	5
Ability to make everyday decisions using good judgment	1	2	3	4	5
Ability to ask for help	1	2	3	4	5
Ability to keep track of belongings	1	2	3	4	5
Ability to attend to daily schedule (arrive on time, etc.)	1	2	3	4	5
Ability to prioritize	1	2	3	4	5
Ability to relate to LD peers	1	2	3	4	5
Ability to relate to non-LD peers	1	2	3	4	5
Ability to relate to teachers, supervisors, etc.	1	2	3	4	5
Ability to relate to siblings	1	2	3	4	5
Ability to Budget money/make purchases	1	2	3	4	5

Signature Date