Hillcrest Academy - Admissions Packet

Completion of the following items is required prior to placement

Student's Name: _____ **DOB:** _____

- **LEGAL INFORMATION & CONSENTS:**
  - _____ Student Profile Sheet
  - _____ Legal Status Change
  - _____ Behavioral Management Policy & Consent
  - _____ Access To & Release of Confidential Records Consent
  - _____ Use of Photographs
  - _____ Field Trips

- **MEDICAL REQUIREMENTS & CONSENTS:**
  - _____ Medical Insurance Coverage Information
  - _____ Birth Certificate
  - _____ Social Security Card
  - _____ Insurance Card
  - _____ Medication Administration Consent
  - _____ Medication Administration - Over the Counter Medication Consent
  - _____ Medication Order
  - _____ Emergency Treatment Consent
  - _____ **Pre-Placement Physical Exam**
  - _____ **Immunization Records**
  - _____ **TB Test**
  - _____ **Free of Communicable & Infectious Disease Statement**

- **FINANCIAL INFORMATION:** ***To Be Provided by Funding Agency*:**
  - _____ IEP
  - _____ Placement Agreement
  - _____ Income Verification

- **OTHER INFORMATION:**
  - _____ Psychological Evaluation
  - _____ Psychiatric Evaluation
  - _____ Behavioral Plan
  - _____ Functional Behavioral Assessment

Send Completed Packet Directly To:

Jackie Mercado, Admissions Coordinator
Hillcrest Educational Centers, Inc.
788 South Street
Pittsfield, Massachusetts 01201

STUDENT PROFILE SHEET
(Please Print)

Name: _____ **Date of Admission:** _____

D.O.B. _____

Gender: _____ Hair Color: _____ Height: _____ Social Security #: _____ - _____ - _____
Race: _____ Eye Color: _____ Weight: _____ Hearing Aids: Yes / No
Place of Birth: _____ Glasses: Yes / No
Citizenship: _____ Braces: Yes / No
Primary Language: (Student) _____ (Family) _____
Self-Preservation Skills: _____
i.e. The ability to egress in the event of a fire.

Legal Guardian: _____ Phone #: _____
LEA: _____ Phone #: _____
Funding Source (s): _____
Custody Status: _____
Agency Contact: _____ Phone #: _____

Family Information: Parental Status: *(Please Circle)* Married Single Divorced Widowed

Father's Name & Address: _____ Phone #: _____
_____ Birthplace: _____
_____

Mother's Name & Address: _____ Phone #: _____
_____ Birthplace: _____
_____ Maiden Name: _____

Primary Care Taker: _____ Phone #: _____
Address: _____ Relationship: _____
_____

Emergency Contact: _____ Phone #: _____
Address: _____ Relationship: _____
_____

Emergency Contact: _____ Phone #: _____
Address: _____ Relationship: _____
_____

LEGAL STATUS CHANGE NOTIFICATION

(Please Print)

Student's Full Name: _____

As _____ 's parent or legal guardian, I agree to notify Hillcrest Academy in the event this child's legal status changes. Possible changes include, but are not limited to, place of legal residence, guardianship, custody and emancipation.

_____ I agree to provide notification to Hillcrest Academy if there is a change in the student's legal status.

Signature: _____

BEHAVIORAL MANAGEMENT POLICY

All interactions with students of Hillcrest Academy are conducted with the goal of de-escalating or preventing dangerous and/or violent behavior. Physical intervention is used in compliance with state regulation only when one or a combination of the following criteria is met:

1. The student is demonstrating by her/his actions that she/he is immanently dangerous (or – "presents an immanent danger") to her/him self or others.
2. No other non-physical intervention has been or is likely to be effective in averting the immanent danger.

Physical intervention is not used for non-compliance, threatening, or verbal aggression unless these behaviors meet the criteria stated above. When verbal intervention has failed to help a student control him or herself, a physical intervention will be initiated. The progression of physical intervention begins with the least restrictive intervention and progresses on a continuum to the most restrictive, depending on the nature of the situation and the degree of dangerous behaviors that the student is presenting.

Physical intervention may consist of escorting a student to another area; holding the student while upright; holding the student while sitting; or holding the student while the student is lying on the ground. All Hillcrest Academy staff receives physical intervention training and Hillcrest Academy only uses intervention "holds" that are approved by DOE and the Office for Childcare Services. However, despite these safeguards, there is always the risk of injury to students and staff. ***By signing this consent form, I understand that there may be situations where my child may need to be restrained and I understand that there may be injuries to my child incurred even when a restraint is undertaken in an appropriate fashion.***

BEHAVIORAL MANAGEMENT PARENT/GUARDIAN CONSENT FORM

Having read the above, I consent to the Behavior Management program outlined above and agree that physical intervention restraints may be employed with _____ when deemed necessary by Hillcrest Academy staff.

(Student's name)

_____ I agree to the use of the interventions _____ _____

Parent/Guardian signature Date

ACCESS TO & RELEASE OF CONFIDENTIAL RECORDS

I, _____ , the parent/guardian/custodial agency/LEA of _____ , hereby give my consent of Hillcrest Academy to receive and review all records, documents, and other information concerning the education and treatment for _____

(Student's name)

This includes team evaluations, materials, medical records, progress summaries, and information from past placements. I also authorize all prior teachers, physicians, psychologists, therapists or other persons who have worked with my child to speak with Hillcrest Academy employees regarding my child.

I understand that Hillcrest will consider this material confidential. Records will be released only to the following individuals or entities subject to applicable law:

1. The student (once the student reaches the age of 18).
2. The student's parents/guardians, if the student is under the age of 18.
3. The student's legal guardian(s) or other authorized representative, Hillcrest Academy's staff, employees and consultants providing services to the students.
4. Persons authorized by licensing agencies (e.g., the Office for Child Care Services, the Department of Education, the Department of Social Services, the Department of Mental Health) that have the responsibility of monitoring the quality of services being provided to the student.
5. The student's attorney or an advocate who has been authorized by the student, a court, the student's guardian(s) or the student's parents/guardians.
6. In the event that the student is being transferred from Hillcrest Academy to another program or school, the program or school to which the student is being transferred.
7. Facilities/programs/schools that are considering the student for admission, ***but only after verbal or written consent has been obtained from the appropriate parent or custodial agency.***

I also understand that the release of or access to confidential records will include inspection of the records.

I HAVE READ THE ABOVE FORM AND UNDERSTAND ALL OF ITS TERMS. I HEREBY GIVE MY CONSENT TO HILLCREST ACADEMY TO RECEIVE, REVIEW, RELEASE AND PROVIDE ACCESS TO ALL RECORDS, DOCUMENTS AND INFORMATION AS SET FORTH IN THIS FORM.

Parent/Guardian/LEA/Custodial Agency: _____

Date: _____

PARENT/GUARDIAN CONSENT FORM

Use of: Photographs, Audio-Visual Films, Name

_____ **I DO** give my permission to take and publish photographs, sound recording and films of my child/ward, and to identify my child's/ward's name in print for purposes of staff and parent training, orientation, observation, documentation and public relations.

_____ **I DO NOT** give my permission to take or publish photographs, sound recordings, or films of my child, or to identify my child's name in print.

_____ _____
(Parent/Guardian Signature) (Date)

Athletics, Educational/Field Trips

I, _____ , the parent/guardian/custodial agency of _____ understand that field trips may be conducted by Hillcrest Academy as part of the program. I hereby authorize such field trips for my child. I also understand that my child may participate in contact and other sports including basketball, baseball, soccer, softball, skiing, snow boarding, roller blading, ropes course and the Special Olympics.

I also understand that, from time to time, my child will participate in an off-campus trip with staff members. These trips may not constitute a formal Hillcrest Academy "field trip." For example, a student may go to a restaurant with a staff member for a meal, or a student may go shopping with a staff member at a supermarket. In addition, students may go on "field trips" with staff and other students. I hereby authorize such off-campus trips for my child.

Prior to an off campus trip, Hillcrest Academy will send a permission slip to the parents/guardian for signed consent and return. Students who do not have their parental/guardian consent will remain on campus.

_____ **I/We hereby give my/our consent to field trips under the conditions set forth in this form.**

_____ _____
(Parent/Guardian Signature) (Date)

MEDICAL REQUIREMENTS FOR ADMISSION

The following is a listing of medical information/requirements for Hillcrest Academy that must be submitted ***prior to admission of new students***. We have provided our forms for some of these items for your convenience. You may also submit records on your forms if you prefer.

- Documentation of medical insurance and a copy of the child's birth certificate and Social Security card.
- Request signed by the parent/guardian to continue present medications, including prescription(s) or physician's orders for medications **along with a 30-day supply**.
- Report of Hepatitis A, B and C screening within the prior month with lab results.
- Results of most recent laboratory testing and other indicated special testing (i.e.: EEG, EKG, and Baseline EKG etc.).
- Reports of most recent vision, hearing, and dental examinations, including optical prescription if glasses are worn.
- Up-to-date medical history including allergies.
- Complete physical examination **within the past six months**.
- Records of Immunizations.
- Physician's statement that child is free of communicable & infectious disease (included on Physical form).
- Records of results of TB testing within the last 60 days.

Hillcrest Academy reserves the right to admit without complete submission of this data.

*** ***

For children entering Hillcrest Academy with braces the parent/guardian must be responsible for ongoing follow-up required, including transportation.

MEDICAL INSURANCE COVERAGE INFORMATION

(This form must be completely filled out)

Student's Name: _____

What type of medical insurance does student have? _____

Private Insurance: _____ Yes **{attach copy of card}**

Name of Company: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Social Security Number: _____

Is there a prescription plan? _____ Yes _____ No

If yes, attach copy of card and information about plan.

Is there a dental plan? _____ Yes _____ No

Member services telephone: _____

State Medical Assistance Program: _____ Yes **{attach copy of card}**

State: _____

ID Number/ Medicaid Client ID#: _____

Other: _____

REMEMBER:

You must attach copies of the:

- *Current Insurance Card*
- *Birth Certificate*
- *Social Security card*

WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

Name of Student: _____

Date of Birth: _____ Gender: _____

Name of Parent / Guardian: _____

Address: _____

Telephone Number (Home): _____ Work: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

My child is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all medication the child is receiving, including those given during the school day:

1. _____ 3. _____

2. _____ 4. _____

CONSENT

1. I give permission to have the school nurse or personnel designated by the school nurse give the following medication: _____
   Name of Medication

   prescribed by: _____
   Name of Prescribing Physician

2. I give permission to the school nurse to share with appropriate school personnel, information relative to the prescribed medicine administration, e.g. adverse side effects, as he/she determines necessary for my child's health and safety. YES _____ NO _____

(Please note: Medication should be delivered in a pharmacy or manufacturer-labeled container by a parent or guardian. Students cannot transport medications. Please ask your pharmacy to provide separate containers for home and school. No more than a thirty-day supply of medication should be delivered to the school. I understand that I may retrieve the medicine form the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.)

Signature of Parent or Guardian: _____

Relationship to Student: _____

CONSENT FOR MEDICATION ADMINISTRATION
PERMISSION TO GIVE (OVER THE COUNTER) MEDICATION

I/We, _____ , the parent and/or guardian hereby give consent for my child/ward, _____
to receive these over the counter preventatives/medications at the nurses discretion:

Sunscreen
Kaopectate
Maalox (Tums)
Tylenol
Motrin
Benadryl (For allergic reactions)
Calamine lotion (For itch and pain related to the outdoors)
Ipecac (For poison control)
Sudafed
Cough Syrup (Cough drops)
Triple Antibiotic Ointment

Please cross out or write below the preferred treatment during illness or while administering first aide treatment.

Additional comments and concerns

_____
_____
_____
_____
_____
_____
_____

Parent / Legal Guardian Signature: _____

Date: _____

MEDICATION ORDER

(To be completed by a Licensed Physician, Nurse Practitioner or others authorized by Chapter 49C of MGL)

Name of Student: _____ Date of Birth: _____

Address: _____ Grade: _____

Name of Prescribing Physician: _____ Title: _____

Business Telephone Number: _____ Emergency Phone: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Specific direction or information for administration: _____

Date of Order: _____ Discontinuation Date: _____

**Diagnosis:* _____

**Any other Medical Condition:* _____

Optional Information

1. Special side effects, contraindications or possible adverse reactions to be observed: _____

2. The date of the next scheduled visit or when advised to return to prescribing physician: _____

_____
Physician Signature

**** If not in violation of confidentiality***

EMERGENCY TREATMENT CONSENT

I, _____ , as the parent/guardian of _____ a student of Hillcrest Academy, give consent for emergency treatment and transportation to a medical facility as deemed necessary by the School School Nurse or Staff.

Parent / Legal Guardian Signature: _____

Date: _____

Primary Care Physician: _____

Telephone Number: _____

Hillcrest
Educational Centers

Pre-Placement Physical Exam

Name of Student: _____ **Date of Birth:** _____

Diagnoses:

_____
_____
_____
_____
_____

Current Medications: (*please attach signed prescriptions)*

_____
_____
_____
_____
_____

Allergies: _____
_____
_____
_____

Past Medical History: _____
_____
_____
_____

Prenatal/Birth/Development History: _____
_____
_____
_____

Family History: _____
_____
_____

Social/Environmental History: _____
_____
_____
_____

Prior Consultations with Sub-Specialists – e.g. Neurology, Endocrinology, Cardiology (*Please attach to exam form)*

_____
_____
_____
_____

EKG Date: _____ **Audio Screenings:** _____
EEG Date: _____ **Vision Screenings:** _____

Pertinent Lab and Radiological Edams including CT or MRI: _____
_____
_____
_____

Hillcrest
Educational Centers

Pre-Placement Physical Exam

Name of Student: _____ **Date of Birth:** _____

Physical Exam Date: _____

TB Risk:

☐ PPD date: _____ Result: +/- _____

(Must be done within 60 days of Admission)

OR

☐ This student has been assessed to be at LOW risk for TB, and therefore a PPD test is not recommended.

School Activity:

☐ This student may fully participate in school programs without restrictions.

☐ This student has the following restrictions for program participation at school:

_____

_____

As examining physician, my signature on this form indicates that I have completed an exam on the date listed above and at this time the above individual is free of communicable and infectious diseases.

Name of physician (please print): _____ Office #: _____

_____ _____

Signature of physician/PA/NP Date

PLEASE:

1. **ATTACH A COPY OF IMMUNIZATION RECORDS**
2. **FOR STUDENTS WITH SIGNIFICANT ALLERGIES OR ASTHMA, ATTACH AN EXPLANATION OF REACTION AND TREATMENT PLAN.**

2019-2020 Massachusetts Application for Free and Reduced Price School Meals

STOP

If you have received a **Notice of Direct Certification – FREE** from the school district for free meals, **do not** complete this application. If you have received a **Notice of Direct Certification – REDUCED PRICE** from the school district for reduced price meals, this application may be submitted. **DO** let the school know if any children in the household are not listed on the **Notice of Direct Certification – FREE** letter you received.

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12 (If more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related." Children in **Foster** care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read *How to Apply for Free and Reduced Price School Meals* for more information.

Child's First Name	MI	Child's Last Name	School Name	Grade	Student? Circle Yes or No	Foster	Homeless	Migrant	Runaway
					Y N	☐	☐	☐	☐
					Y N	☐	☐	☐	☐
					Y N	☐	☐	☐	☐
					Y N	☐	☐	☐	☐
					Y N	☐	☐	☐	☐
					Y N	☐	☐	☐	☐

(Check all that apply)

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

Write the ***Agency ID Number***, then go to **STEP 4** (Do not complete STEP 3) ***EBT number not accepted; SNAP award letter may be requested***

Agency ID Number: _____

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Review the charts titled "Sources of Income" for more information. The "Sources of Income for Children" chart will help you with the Child Income section. The "Sources of Income for Adults" chart will help you with the All Adult Household Members section

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here:

Child Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/ Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions / Retirement / All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
		○	○	○	○		○	○	○	○		○	○	○	○
		○	○	○	○		○	○	○	○		○	○	○	○
		○	○	○	○		○	○	○	○		○	○	○	○
		○	○	○	○		○	○	○	○		○	○	○	○
		○	○	○	○		○	○	○	○		○	○	○	○

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member XXX-XX- ☐☐☐☐ **Check if no SSN** ☐

STEP 4 Contact Information and Adult Signature

Mail Completed Form To: Hillcrest Academy 400 Columbus Avenue #1, Pittsfield, MA 01201

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) _____ Apt # _____ City _____ State _____ Zip _____ Daytime Phone and Email (optional) _____

Printed name of adult signing the form _____ Signature of adult _____ Today's date _____ Error prone ☐

INSTRUCTIONS — Sources of Income

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, BAS, or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

Ethnicity (check one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

OPTIONAL — Children's Racial and Ethnic Identities

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410

fax: (202) 690-7442; or
email: program.intake@usda.gov.

This institution is an equal opportunity provider.

For School Use Only

2019-2020 Massachusetts Application for Free and Reduced Price School Meals

Total Income | **Household Size**

Annual Income Conversion:

Weekly	x 52
Every 2 Weeks	x 26
Twice A Month	x 24
Monthly	x 12

Only annualize income if there are multiple pay frequencies

How often?

Weekly	Bi-Weekly	2x Month	Monthly	Annually
○	○	○	○	○

Eligibility:

Free	Reduced	Denied
○	○	○

Categorical Eligibility ☐

Determining Official's Signature | **Date** | **Confirming Official's Signature** | **Date** | **Verifying Official's Signature** | **Date**