



*Transitioning Youth with disabilities  
to a life with purpose*

**Located at Evangel University**  
Education Department, Trask Hall, Ste 201H  
1111 N Glenstone Ave  
Springfield, MO 65802

**Mail to:** Achieve of Southwest Missouri  
P. O. Box 8283  
Springfield, MO 65801

**NEW Email:** [AchieveSWMO@evangel.edu](mailto:AchieveSWMO@evangel.edu)

**Website:** [www.achieveswmo.com](http://www.achieveswmo.com)

**Facebook:** Achieve SWMO

**Phone:** 417-865-2815, ext. 8544

## APPLICATION FOR ADMISSION

Thank you for your interest in the Achieve of Southwest Missouri Program on the campus of Evangel University.

Complete this application to the best of your ability. If needed, you may ask a parent or guardian for assistance.

Please **print or type legibly**. If more space is required for responses, attach an additional sheet.

You are encouraged to keep a copy of the completed application for your reference.

## STUDENT INFORMATION

Name: \_\_\_\_\_ Gender:  Male  Female  
Last First Middle Preferred

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Permanent Address: \_\_\_\_\_  
(if different) Street City State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever sought out Vocational Rehabilitation services?  No  Yes

Are you currently receiving Vocational Rehabilitation services?  No  Yes, list the Vocational Rehabilitation Counselor's name, email, and phone number:  
\_\_\_\_\_

Are you currently covered under a medical insurance plan?  No  Yes

How did you learn about Achieve of Southwest Missouri?

School Teacher/Counselor/Principal  Flyer  Service Provider  Conference/Fair  Internet Search

Agency: \_\_\_\_\_  Other: \_\_\_\_\_

**FAMILY/GUARDIAN INFORMATION**Are you your own guardian?  Yes  No

If no, list the name of your legal guardian: \_\_\_\_\_

Whom do you live with?  Both Parents  Mother  Father  Guardian  Grandparents Others: \_\_\_\_\_What is the name of the primary contact for communication with Achieve? \_\_\_\_\_

What is the preferred method of communication?

 Phone: \_\_\_\_\_  Email: \_\_\_\_\_ Text: \_\_\_\_\_**Mother/Guardian:**Name: \_\_\_\_\_  
Last First MiddleMailing Address: \_\_\_\_\_  
(if different) Street City State Zip Code

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Father/Guardian:**Name: \_\_\_\_\_  
Last First MiddleMailing Address: \_\_\_\_\_  
(if different) Street City State Zip Code

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

Why are you interested in the Achieve Program?

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Describe your motivation to participate in the Achieve Program.

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Describe any concerns you may have about your participation in Achieve.

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Describe how you have prepared for transition to life after High School.

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Have you used public transportation on your own to get to school or work?  Yes  No

Are you able to use a cell phone independently?  Yes  No  Do not have a cell phone

Do you understand, you will be required to have a cell phone in the Achieve Program?  Yes  No

Do you have a driver's license?  Yes  No

Do you have your own vehicle?  Yes  No

**EDUCATION HISTORY OF STUDENT**  
(include K-12 and any post-secondary experiences)

NAME OF SCHOOL	LOCATION	YEARS ATTENDED	PUBLIC, PRIVATE, or SPECIALIZED	RECEIVED SPECIAL EDUCATION SERVICES?	COMPLETED Yes or No

When will/did you complete your high school education (month/year)? \_\_\_\_\_

What type of high school diploma will/did you earn? \_\_\_\_\_

Do/Did you have an IEP in high school?  No  Yes, submit a copy with the application materials.

Do/Did you have a 504 Plan in high school?  No  Yes, submit a copy with the application materials.

Do/Did you have a Behavior Plan in high school?  No  Yes, submit a copy with the application materials.

Identify the type of class setting/placement you participated in during the last two years of high school:

- Inside a regular/general education class 100% of the time
- Inside a regular/general education class at least 80% of the time
- Inside regular/general education class 40% to 79% of the time
- Inside a regular/general education class less than 40% of the time

Indicate your level of independence in an unfamiliar environment:

- Complete independence
- Minimal Supervision
- Moderate Supervision
- Complete Supervision
- Other \_\_\_\_\_

Do/Did you receive services/supports outside the school setting?  No  Yes, list what services and/or supports are/were received:

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Indicate, in your opinion, how you feel you best learn new information:

- Auditory
- Visual
- Memorization
- Repetition
- Hands-on
- Experiential Learning
- Other \_\_\_\_\_

Describe any technology or assistive technology you currently use, or have used, to assist in living, learning, or working.

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What, if any, accommodations are needed at volunteer or work activities? (e.g., job coach, visual cues)?

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**EXTRACURRICULAR/VOLUNTEER ACTIVITIES**

ORGANIZATION	ACTIVITY DESCRIPTION	DATES	FREQUENCY

**EMPLOYMENT HISTORY**

EMPLOYER	POSITION and/or JOB RESPONSIBILITIES	DATES OF EMPLOYMENT HOURS/WEEK	REASON FOR LEAVING	PAID or VOLUNTEER	USED A JOB COACH YES/NO

To assist in the placement of a volunteer vocational opportunity, describe the circumstances regarding any difficult volunteer or work experiences you may have had. If none, indicate none.

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### MEDICAL/DISABILITY HISTORY

Name of Student's Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Clinic (if applicable) Street City State Zip Code

Date of last medical exam: \_\_\_\_\_

Do you require any assistance in self-care?  No  Yes, explain:  
 \_\_\_\_\_

Do you require any assistance in mobility?  No  Yes  
 If yes, does the student use any of the following mobility aids?  
 Prosthesis, specify: \_\_\_\_\_  Braces  Crutches  Cane  Manual Wheelchair  
 Motorized Wheelchair/Cart  Other: \_\_\_\_\_

Do you require a service animal?  No  Yes, specify: \_\_\_\_\_

Have you ever had a seizure?  No  Yes, explain and provide dates and medical treatment:  
 \_\_\_\_\_  
 \_\_\_\_\_

Provide information on all medical conditions or diagnoses, other than common childhood illnesses.

MEDICAL CONDITION	DATE OF DIAGNOSIS	DESCRIPTION OF MEDICAL CONDITION	DAILY LIVING IMPACTED? Yes or No

Current Medications student is taking:

No medications are required continuously

MEDICATION	AMOUNT and FREQUENCY	PURPOSE	PRESCRIBED or OVER THE COUNTER

Achieve does not provide assistance with dispensing medications, or perform services typically provided by a nurse or personal care attendant. As a student at Achieve, you will be required to be aware of and manage your own medication and/or personal care needs. Do you understand, and are able to perform, all medication and personal care needs?  No  Yes

Explain: \_\_\_\_\_  
 \_\_\_\_\_

Provide information about any hospitalizations the student has had:

DATE OF HOSPITALIZATION	REASON FOR HOSPITALIZATION



Have you had any incidents of aggressive physical or verbal behavior requiring intervention?  No  Yes, list the date and nature of the situation(s):

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Do you have a history of legal violations, arrest, or probation?  No  Yes, list the date and nature of the situation(s):

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### REFERENCES

A minimum of three (3) references are required to be completed by **non-relatives who have known you for at least six months.**

**One reference must be from an educator.** Examples of other reference requests could be another educator, supervisor, minister, affiliated organization leader, employer, family friend, or a service provider.

By providing the below requested information, you are indicating consent to contact your references and releasing them from any liability in the information they provide. List below, the requested information for your reference choices:

List references below:

1.	_____	_____
	Name	Title
	_____	_____
	Organization	Contact email or phone
2.	_____	_____
	Name	Title
	_____	_____
	Organization	Contact email or phone
3.	_____	_____
	Name	Title
	_____	_____
	Organization	Contact email or phone

If applicable, the following person assisted me in completing this application:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

My signature below indicates that all information contained in this application is factually correct and complete. I understand that the misrepresentation or omission of application information is sufficient grounds for canceling my admission or registration. I understand that I will not receive undergraduate credit for any classes or activities participated in while a student of Achieve of Southwest Missouri.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

My signature below indicates that all information contained in this application is factually correct and complete. I understand that the misrepresentation or omission of application information is sufficient grounds for canceling the student's admission or registration. I understand the student will not receive undergraduate credit for any classes or activities participated in while a student of Achieve of Southwest Missouri.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_