The Matthew Reardon
CENTER FOR AUTISM
for the love of children

11500 Middleground Rd
Savannah, GA 31419

P: (912)355-9098
F: (912)352-2460

MatthewReardon.org
Info@MatthwReardon.org

Admissions Application for Advance Academy

Thank you for your interest in Advance Academy, Southeast Georgia's only year-round day school for children with autism operated by The Matthew Reardon Center for Autism and accredited by the Georgia Accrediting Commission. Attached is the requested application package. Please review and complete all forms. *The completed application packet should be submitted along with a non-refundable $50 application fee*. Please note the following:

- The Physician's Recommendation form must be completed by the diagnosing physician. This form does not have to reflect a new examination; simply if there are any abnormalities and if immunizations are up to date. The form can be faxed to us at (912) 352-2460.
- Teacher Questionnaires must be submitted separately by two (2) teachers or school personnel who currently work closely with your child.
- Advance Academy is a provider for the Georgia Special Needs Scholarship (SB10) program. Additional needs-based tuition assistance is also available through the Apogee GA Tax Credit Scholarship Program. MRCA's Board of Directors is determined that no child who will benefit from attending Advance Academy be denied access due to financial constraints.
- A copy of your child's most recent **IEP** and **psychological evaluation** must accompany your application.
- A copy of your child's most recent **BSP** (Behavioral Support Plan), if applicable.
- **2024-2025 FEES**: $100 Non-refundable Registration Fee; $17,170 Annual Tuition; $150 Supply Fee. Advance Academy does not offer Afterschool Care.

The admissions process typically includes an observation in the child's current classroom**.** If an observation is required, all parties involved must agree that the observation will take place under normal classroom conditions**. For more information, a copy of the admission guidelines and procedures is attached.**

Thank you for your interest in Advance Academy. Should you have any questions, please do not hesitate to contact one of us at (912) 355-9098.

Ciarra Torres	Kimberly Smith	Patti T. Victor
Advance Academy Director	MRCA Clinical Director	MRCA President/CEO

Student/Child's Name: _____ Student's DOB:_____

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Application DATE:_____

Admission DATE:_____

2024-2025 APPLICATION CHECKLIST

Please submit all required documents together to ensure that the application is processed in a timely manner.

_____ Application fee ($50)

_____ Family Documentation

_____ Complete Copy of Most Current IEP

_____ Complete Copy of Most Current BSP *(Behavioral Support Plan) if applicable*

_____ Complete Copy of Most Recent Psychological Evaluation (3 years or fewer)

_____ Quality of Life Indicator Index

_____ Physician Recommendation (may be submitted separately)

_____ Current Immunization Record

_____ Most recent ABA Treatment Plan, if applicable

_____ Two (2) Teacher Questionnaires (to be submitted separately by teacher)

MRCA Completes this part:

DATE RECEIVED:_____ Received by: _____

DATE REVIEW COMPLETED:_____ Completed by: _____

DATE REVIEWED BY ADMISSIONS COMMITTEE: _____

DATE/STATUS FINAL DETERMINATION: _____ ELIGIBLE INELIGIBLE

Student/Child's Name: _____ Student's DOB:_____

2024-2025 Advance Academy

Date Submitted_____

Family Documentation

Application DATE: _____ Notification Date:_____

Applicant Name:_____Relationship to Student:_____

Mother's Name:_____Father's Name:_____

Student's Address:_____
(Street, PO Box, City, State, Zip Code)

Parent/Guardian Address (if different):_____

Home Phone:_____ Email:_____

Cell Phones (M)_____ (F)_____

How did you learn about MRCA? ( ) Friend ( ) Advocate ( ) Teacher/District ( ) Internet

( ) Clinical Referral – referring Provider's Name _____

Child's Current School & District: _____

School Address:_____
(Street, PO Box, City, State, Zip Code)

School Phone/fax:_____

Length of time at current school _____ Current Grade:_____

Start date of current IEP:_____Date of most recent Re-evaluation: _____

Is your child currently enrolled in SSI? Yes No

Is your child currently enrolled in Medicaid/Katie Beckett? Yes No

Tell us something unique about your child, describe his/her special interests, and/or what you enjoy most about your child.

_____

_____

_____

_____

Student/Child's Name: _____ Student's DOB:_____

STUDENT'S BEHAVIORAL HISTORY

Has your child exhibited any of the following behaviors? If so, please indicate approximate date of last occurrence or, if the behavior is still a concern, how frequently the behavior occurs:

1. Aggression? DATE_____ Frequency_____
2. Self-injury? DATE_____ Frequency_____
3. Destructive behavior? DATE_____ Frequency_____
4. Verbal outburst? DATE_____ Frequency_____
5. Elopement/Running? DATE_____ Frequency_____
6. Other_____? DATE_____ Frequency_____

Has your child ever had a behavioral crisis requiring emergency assistance (i.e., mobile crisis)? **Yes** **No**

If Yes, please provide date(s) and details:_____

_____

_____

Has your child ever had a behavioral/psychological crisis resulting in hospitalization? **Yes** **No**

If Yes, please provide date(s) and details:_____

_____

_____

Further Comments/Concerns about Behavior:_____

_____

_____

Is your child toilet trained? _____ Age training completed: _____

Please complete the following statements:

My priority for the developmental areas I want my child to master are:
(please indicate using numbers; *example* (1) Writing, (2) Life Skills, (3) Reading, etc.)

( ) Reading ( ) Writing ( ) Social Skills ( ) Social Studies

( ) Mathematics ( ) Communication ( ) Life Skills ( ) Science

( )Technology ( ) Vocational Skills ( ) Other_____

As a parent/guardian, I especially appreciate it when (including aspects of your relationship with school staff that are important to you and your child)…

_____

_____

_____

Student/Child's Name: _____ Student's DOB:_____

Describe where you see your child in ***5 years***.

_____

_____

_____

What are your life-time goals for your child?

_____

_____

_____

HOUSEHOLD INFORMATION

Please list the members of child's household(s) and other important relationships:

NAME AGE RELATIONSHIP TO STUDENT

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Student/Child's Name: _____ Student's DOB:_____

2024-2025 FAMILY STATISTICS

Please complete the following section. The information you provide will be kept confidential and will be released in summary form only for State and Federal statistical reporting.

MARITAL STATUS (parents)
Check One

_____ Single (never married)
_____ Married
_____ Divorced
_____ Widowed

EDUCATION (Check highest *COMPLETED*)

	MOM	DAD
Kindergarten - 6th Grade	( )	( )
7th – 9th Grade	( )	( )
10th – 12th Grade	( )	( )
High School Diploma/GED	( )	( )
Some College	( )	( )
Associate's Degree	( )	( )
Bachelor's Degree	( )	( )
Master's Degree	( )	( )
Doctoral Degree	( )	( )
Unknown	( )	( )

ANNUAL INCOME
Check for family total

_____ $ 0 – 9,999
_____ $ 10,000 – 19,999
_____ $ 20,000 – 39,999
_____ $ 40,000 – 59,999
_____ $ 60,000 – 89,999
_____ $ 90,000 – 119,999
_____ $ 120,000 – 199,999
_____ $ 200,000 +

PARENTS' OCCUPATION(S):

- Mother:_____ Employer:_____
- Father _____Employer:_____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Student/Child's Name: _____ Student's DOB:_____

2024-2025 Advance Academy Application

Communication and Observation Consent Form

Parents: *Please complete this form and return it to Advance Academy as part of your child's application packet:*

I, _____ (parent name), give consent for staff from the Matthew Reardon Center for Autism's Advance Academy to communicate with staff from _____ (current school), regarding an admission application for my child, _____(child name), as outlined below:

- Staff from Advance Academy may communicate with my child's current teacher and classroom staff regarding this application and his/her current performance in school.
- Staff from Advance Academy may enter my child's classroom for an observation. (The admissions process typically includes an observation in the child's current classroom**.** If an observation is required, all parties involved understand that the observation will take place under normal classroom conditions**.**)

This consent will be effective for six (6) months from the signature date below.

_____ _____
Signature Date

_____
Printed Name

Current School Name:_____ Phone #:_____

Lead Teacher Name:_____ Email:_____

Student/Child's Name: _____ Student's DOB:_____

2024-2025 Family Stress/Quality of Life Index

Please rate how stressful you currently find each of the following aspects of your child's life	Not stressful	Somewhat stressful at times	Often stressful	Very stressful most of the time	Always extremely stressful- often have difficulty coping
1. Disruptions to your child's typical daily schedule or routine	0	1	2	3	4
2. Extended school vacations or breaks	0	1	2	3	4
3. Child's ability to participate in family functions or holidays	0	1	2	3	4
4. Ability to eat out at a restaurant as a family	0	1	2	3	4
5. Ability to go to a store with your child (walking down aisles, waiting in line, etc.)	0	1	2	3	4
6. Child's behavior during routine medical appointments (waiting room, exam, etc.)	0	1	2	3	4
7. Your child's current sleep patterns	0	1	2	3	4
8. Your child's eating habits	0	1	2	3	4
9. Your child's ability to complete self-care routines (toileting, dress independently, etc.)	0	1	2	3	4
10. Your child's needs and their impact on other members of the family (e.g. siblings)	0	1	2	3	4
11. Your child's needs effect on relationship between parents	0	1	2	3	4
12. Child's current performance and progress in school	0	1	2	3	4
13. Thoughts of your child's life after they finish school	0	1	2	3	4

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Physician Recommendation

Child/Patient's name:_____ DOB: _____

Physician's Name:_____

Physician's Address:_____

_____

Physician's Phone:_____ Email:_____

****

Child/Patient's Information: Date of Latest Evaluation:_____

Weight _____ Height: _____

Patient is diagnosed with a congenital, traumatic, or acquired neurological disorder **Y N**

Diagnosis:_____

Patient has a related communication/speech and language deficit **Y N**
Specify: _____

Patient exhibits delays in the following areas (Please describe delays) **Y N**
Behavioral:_____
Social:_____
Motor (fine and gross):_____
Cognitive:_____

Are there any specific health issues that need to be monitored while this child is under our care? (weight, vital signs, blood sugar, etc.)_____

_____

Child requires systematic instruction in a 1:1 setting **Y N**

Child demonstrates ability to learn but requires an individualized education setting **Y N**

Child is at risk for regression without a structured year-round program **Y N**

Child requires an educational program that is predictable and routine **Y N**

Child needs a functional approach to address problem behaviors **Y N**

Student/Child's Name: _____ Student's DOB: _____

CHILD/Patient's HEALTH HISTORY (continued)

Special Diet Requirements? ___YES ___NO If yes, please describe: _____

_____

Please list Allergies: _____

_____

Other current/previous health conditions (e.g., seizures, migraines, etc.): _____

_____

_____

Has this patient ever been hospitalized following a behavioral crisis? (Date/Comments) _____

_____

Has this patient ever been hospitalized following a psychological crisis? (Date/Comments) _____

_____

Please list ALL prescribed medications that the patient takes regularly:

Medication: _____ Dose: _____mg TIME: ____ AM/PM
Medication: _____ Dose: _____mg TIME: ____ AM/PM
Medication: _____ Dose: _____mg TIME: ____ AM/PM
Medication: _____ Dose: _____mg TIME: ____ AM/PM
Medication: _____ Dose: _____mg TIME: ____ AM/PM

*****Please attach Patient/Child's current immunization record to this application*****

- Georgia Immunization Certificate (Form 3231) indicating a medical exemption from one or more vaccines. This form must be updated annually. Letters from a child's physician will not be accepted in place of Form 3231

Physician's Name: _____

Physician's Signature: _____ Date: _____

Student/Child's Name: _____ Student's DOB:_____

Physician's Additional Comments:

Student/Child's Name: _____ Student's DOB:_____

2024-2025 Advance Academy Application

Teacher Questionnaire

Date Completed: _____

PARENTS: Please submit this form to two (**2**) teachers or school personnel who work closely with your child along with a stamped envelope addressed to:

Advance Academy Admissions, 11500 Middleground Rd.,Savannah, GA 31419

***TEACHERS: Please take a few minutes to complete this form and return it in the envelope provided. Please contact Ciarra Torres at (912) 355-9098 or CTorres@matthewreardon.org with any questions or concerns.

Student/Child's name:_____DOB:_____

Current School:_____Grade Level:_____

Teacher Completing Form:_____

Teacher Phone:_____ Email:_____

How long have you known this student? _____

Average number of hours you work with the student (per week):_____

In what capacity do you work with the student ☐Lead Teacher ☐Assistant Teacher ☐1:1

Other (please explain) _____

Please rate the student's performance in each of the following categories:

	Excellent	Good	Fair	Poor
Overall Attendance	☐	☐	☐	☐
Appropriately Interacts with Classmates	☐	☐	☐	☐
Appropriately Interacts with School Staff	☐	☐	☐	☐
Independently Follows Classroom Rules	☐	☐	☐	☐
Appropriately Participates in the Classroom	☐	☐	☐	☐
Can Communicate his/her Personal Needs	☐	☐	☐	☐
Demonstrates Age-Appropriate Social Skills	☐	☐	☐	☐
Supportive/Strategic Parental Engagement	☐	☐	☐	☐
Communication between Parents and School	☐	☐	☐	☐

Student/Child's Name: _____ Student's DOB: _____

Please provide details about anything rated <u>POOR</u> or <u>FAIR</u> on the previous page. _____

_____

_____

_____

What are this student's STRENGTHS? _____

_____

_____

What are this student's CHALLENGES? _____

_____

_____

Please describe the reinforcement & discipline strategies used with this student: _____

_____

_____

Please describe any factors (e.g. diagnosis, family situation, diet, attendance) which have impacted the student's performance in school: _____

_____

_____

Please list at least three motivators and items/activities this student enjoys in the classroom. _____

_____

Additional Comments: _____

_____

_____

_____

_____ _____

Signature Date

Thank you for taking the time to complete this form.

Student/Child's Name: _____ Student's DOB:_____

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Appropriately Interacts with Classmates	☐	☐	☐	☐
Appropriately Interacts with School Staff	☐	☐	☐	☐
Independently Follows Classroom Rules	☐	☐	☐	☐
Appropriately Participates in the Classroom	☐	☐	☐	☐
Can Communicate his/her Personal Needs	☐	☐	☐	☐
Demonstrates Age-Appropriate Social Skills	☐	☐	☐	☐
Supportive/Strategic Parental Engagement	☐	☐	☐	☐
Communication between Parents and School	☐	☐	☐	☐

Student/Child's Name: _____ Student's DOB: _____

Please provide details about anything rated <u>POOR</u> or <u>FAIR</u> on the previous page. _____

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_____

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_____

_____

_____

_____ _____

Signature Date

Thank you for taking the time to complete this form.