Application Packet

Project Partners:

November, 2025

Application Purpose & Guidelines

Thank you for your interest in the BELL Program at Roberts Wesleyan University. The purpose of this application packet is to outline the skill set of the ***Bridge to*** **Earning, Learning and** ***Living*** student candidate. This application then enables the Selection Committee* to properly assess each student candidate's skills, abilities and background. A parent, student, counselor, teacher or employer may be contacted by the Selection Committee to gather additional information. Our final goal is to select students who will successfully achieve a certificate in the ***Bridge to Earning, Learning and Living*** program and reach the outcomes of academic enrichment, socialization and the acquisition of skills necessary for sustainable gainful employment.

The Selection Committee will include representatives from BOCES 2, Roberts Wesleyan University, and CP Rochester. Respective members will be utilized in consultation as needed.

The Selection Process includes the following guidelines:

1. Recruitment happens in the spring semester for fall semester enrollment. To ensure proper assessment, all students must complete this packet of information to be considered for participation in the ***Bridge to Earning, Learning and Living by Monday January 19th, 2026***.

2. All applicants **must** participate in the BELL Shadow Day held on **February 11th, 2026** in order to be considered for an interview**.** All applicants must arrange transportation to and from campus. Arrival is 8am and departure is 2pm. Parents/Guardians/Staff will be asked to leave for the day or can stay on campus in the community areas.

3. The Selection Committee will match the student skill set, interests with academics, social activities and the work experiences which will maximize job skill building and the opportunity for sustainable gainful employment during the interview held on **February 25th, 2026**.

4. **All candidates applying must have completed paperwork and all additional documents asked for handed in by January 19th, 2026 in order for application to be reviewed. Please reach out to Mikaela Tenny, Program Director with any questions and or concerns.**

Email Tenny_Mikaela@roberts.edu
Office Number 585-594-6610

1. **Candidate Information:**

Candidate Name: Last First MI

Date of Birth: Mo/Day/Year [_____][_____][_____]

Sex: □ Male; □ Female

Social Security Number: [_____]—[_____]—[_____]

Current Address: Street

City State Zip

Phone number: (____) _____ *Email:* _____

Medicaid Number: _____

Medicare: _____

Other Insurance: _____

DDSO Eligibility: □ Yes; □ No

2. **In case of emergency, the following person(s) are to be called:**

Name: Last First MI

Relationship: □Parent, □Guardian, □Other

Current Address: Street

City State Zip

Home Phone: (____) _____ *Work Phone:* (____) _____

If unable to reach, call:

Name: Last First MI

Relationship: □ Parent, □ Guardian, □Other

Current Address: Street

City State Zip

Home Phone: (____) _____ *Work Phone:* (____) _____

***Note:** if a candidate has a court appointed Guardian, please attach Guardianship paperwork.

3. **Race (please check one)**

□ American Indian and Alaska Native

□ Asian

□ Black or African-American

□ Hispanic

□ Native Hawaiian and Pacific Islander

□ White

□ Other _____

4. **Primary Language (communication skill) and Secondary Language (communication skill)**
   Please indicate with a check mark and number in order if there are two forms of communication.

   ☐ English

   ☐Spanish

   ☐ American Sign Language

   ☐ Symbolic (Type:)

☐ Communication device (Type:)

☐ Non-verbal

☐ Other _____

5. **Care Manager/Coordinator Name:** _____

Agency Affiliation: _____

Address: Street _____

City _____ State _____ Zip _____

Phone number: (____) _____ *On-call Phone:* (_____) _____

Fax Number: (____) _____ *e-Mail:* _____

Self-Directed Broker (If Applicable) Name: _____

Agency Affiliation: _____

Phone Number: (____) _____ *Email:* _____

6. **School/Program Information:**

Is the candidate attending school or a day program? D Yes, D No

If ***Yes,*** please complete below.

School or Program Name: _____

Contact Name: Last _____ First _____

School/Program

Address: Street _____

City _____ State _____ Zip _____

Contact Phone number: (____) _____

7. **Describe this candidate's disability history.** Please include any specific medical issues in the history. (Please attach a separate sheet if necessary. Please do not state, "refer to…")

Primary Diagnosis _____

Secondary Diagnosis _____

Additional medical information _____

_____

_____

8. **Does this candidate have any known allergies (e.g., to foods, medications, or the environment)?** D Yes, D No. If yes, please list below and include reaction:

_____

_____

_____

***Please Note:** any dietary needs such as low calorie, gluten free, dairy free, etc. needs to be followed by the student as staff cannot monitor .

9. **Has this candidate ever had a seizure?** □ Yes □ No. If *yes,* please answer the following:
    a. When was the last time the candidate had a seizure?_____
    b. How often does the candidate have seizures? _____
    c. Please describe a typical seizure, including physical characteristics and duration. Describe any warning signs that a seizure is about to occur. _____

10. **Are there any medical restrictions to the candidate's diet (i.e., diabetic, low sodium, low cholesterol, gluten free, low calorie, special consistencies)?** _____

11. **Are there any concerns around meal time and/or eating?** _____

12. **Please specify all adaptive equipment used by this candidate. Please explain usage.**
    Helmet _____
    AFOs _____
    Adaptive equipment for meals (including utensils) _____
    Glasses/Contacts _____
    Hearing Aids _____
    Communication Devices _____
    Other _____

13. **Is this candidate capable of self-medication administration?** □ Yes □ No. Please describe any support needed by this candidate for self-medication administration. _____

14. *Please list all current medications*.

Medication	How Much	How Often	Why is Medication Taken	Prescribing MD

15. **Does the candidate demonstrate any of the behaviors below?** (Please indicate frequency)

Behavior	Yes	No	Daily	Weekly	Monthly
Physical Aggression					
Wandering, Running Away					
Destroys Property					
Tantrums					
Self-Injurious Behavior					
Verbal Outbursts					
Mouthing, Swallowing or eating non-food items					
Interactions with others that are not appropriate					
Other (define)					

16. **Does the candidate have a current written behavioral plan?** □ Yes, □ No. If Yes, please complete the following and attach current plan:

a. If there is a plan:

Where is it implemented?_____

Has the plan been effective?_____

Are there things that are more likely to cause the behavior to occur? If so, please explain.

_____

_____

_____

b. If there is no plan in place, what support is needed during challenging behaviors?

_____

_____

_____

_____

c. Is there anything else you would like us to know about this individual's behavior?_____

_____

_____

_____

17. **Has this candidate ever been convicted of a felony or misdemeanor?** □Yes, □ No. If yes, please list date(s) and offense:

_____

_____

_____

18. **Does this candidate have a Sexuality Assessment?** □ Yes, □ No.

If yes, when was it completed? _____

What is the individual's consenting status? _____

_____

19. **Has this candidate applied or been assessed for ACCES-VR services?** □ Yes, □ No.

If yes, when? _____

What was the result? _____

_____

20. **Has this candidate applied for an Employee Training Program (ETP)?** □ Yes, □ No.

If yes, when? _____

What was the result? _____

_____

21. **Social and Recreational Activities**

a. Describe how the candidate interacts with peers, young children and authority figures._____

_____

_____

_____

b. Describe the candidate's favorite activities/hobbies? What supports (including supervision) are needed to participate in these activities?_____

_____

_____

_____

c. *Are there any special concerns when the candidate is in the community? What supports (including supervision) are needed to participate in these activities? (Please include pedestrian skills, ability to interact safely with strangers, travel training, etc.) _____

_____

_____

_____

d. Does the candidate have any special travel needs such as a person to accompany them, special accommodations, or supervision? _____

_____

22. **What is the candidate's evacuation capability?** Is the candidate able to leave a building independently during an emergency? □ Yes, □ No. If *No,* what type of support/assistance is needed?

_____

_____

_____

_____

23. **Please list the level of support needed for the following areas (independent, verbal prompts, physical assist, or total support). **Please note any concerns.**

Toileting_____

Dressing _____

Shopping _____

Telephone Use _____

Social Settings _____

Classes _____

_____

Print Name of person completing this form _____

Relationship to Candidate _____

Signature of person completing form _____

Date _____

CANDIDATE PERSONAL VISION

Please complete the following questions in your own words, assistance can be used to write responses, however responses need to be left as stated by the candidate.

1. **What are your goals and dreams in life?**

2. **Why do you think Roberts Wesleyan University and Bridge to Earning, Learning and Living Program would be beneficial to you? What do you hope to gain?**

Employer Name and Number	Supervisor	Job Title	Tasks	Paid or Voluntary	Dates of Employment

2. List any paid or voluntary positions you have had in the past:

4. **Which of the above positions were your favorite and why?**

5. **Have you ever suddenly left employment or been terminated? Please explain.**

6. **What is your employment goal after you complete the BELL program?**

7. **How would you handle the following situations?**
   a. You arrive at class and discover it has been canceled.
   b. During class, there is an emergency situation.
   c. A stranger asks you to come with him or her.

8. Have you participated in general education classes?

d. If classes were within the past 5 years, what support was required? Were there any accommodations made and/or specific learning strategies that were successful?

e. If you have never taken general education classes or they were prior to 5 years ago, what support do you feel you would require to be successful?

f. What skills would you like to learn while attending this program (vocational, travel training, independent living skills, socialization skills, literacy/GED prep, specific class related skills, etc.)

Thank you for completing this section.

Signature Candidate:_____

Signature of
Guardian:_____

Date:_____

Thank you for completing this form. After signing please attach the following documents in order for application to be reviewed:

- Current Psychological Assessment
- Current Physical
- Current Lifeplan
- Completed HIPAA form ***(CP Rochester BELL Candidate only, found at the end of the application)***
- Notice of Decision or Documentation of Disability ***(CP Rochester BELL Candidate only)***
- Copy of DDP2 ***(CP Rochester BELL Candidate only)***
- Current PPD (under 1 year old) ***(CP Rochester BELL Candidate only)***
- FAFSA Disclaimer (**CP Rochester BELL Candidate only, found at the end of application)**

If there are any questions in determining what partner to be working with please email or call for further discussion.

Student Agreements

As part of the admissions process, the BELL student candidate and a guardian or family member are asked to read, sign and date several documents that become effective once a student is accepted into the BELL Program.
***All documents must be reviewed and signed in order for the application to be reviewed.**

1) Student Contract
2) Liability release waiver for on campus vocational experiences
3) Voller Athletic Center Liability waiver, for participation in fitness and physical education activities.
4) Audio Visual Release

***Please note, upon acceptance there will be a health immunization form that must be complete upon the first day of the semester.**

Student Contract

I, _____, understand that if I am accepted into the **Roberts Wesleyan University and Bridge to Earning, Learning and Living Program** I must abide by the following terms and conditions:

1. I will complete the four-semester (2 year) academic, social and work training requirements.
2. I will regularly attend the program: **Monday-Friday 8am-2pm per University Calendar**
3. I understand that the **Roberts Wesleyan University and Bridge to Earning, Learning and Living Program** follows the Roberts School Calendar. This calendar is not fully aligned with the public school calendar. It is my responsibility to attend all Roberts classes even if my school district or program is closed. I will arrange my own transportation.
4. I will dress appropriately and wear required attire.
5. I will call or email my instructor and departmental supervisors when I am absent or tardy.
6. I will make up any instructional work missed due to excused absences as appropriate.
7. I understand that I am responsible for transportation to the college for events and activities that occur after regular hours of M-F, 8:00 a.m. – 2:00 p.m., or when my District or agency is not in session or scheduled to provide transportation.
8. I will follow all the rules established by the program and university .
9. I will attend scheduled meetings (included lessons) with my support team, parents, teachers, and mentors.
10. I will be an active participant and communicate any issues to my support team.
11. I will attend 8 after hours University social events throughout the four-semesters.
12. I/we grant permission and understand that my/our son/daughter will remain on campus after school hours or walk off campus after school hours or ride with others off campus after school hours with no staff or adult(s) present. I/we understand and agree that Monroe 2-Orleans BOCES and CP Rochester will have no responsibility or liability with respect to any personal injuries whatsoever including death and/or abduction and/or personal property damage or injury, civil or criminal or otherwise, etc., that may occur once the program ends for the day and my/our child remains on campus or leaves the program and/or grounds. I am aware that there are after hour events and at times I could return to campus when there are no CP Rochester or BOCES 2 staff**. By signing this I indicate my/our child's ability to do this independently.** I recognize that part of my responsibility would be to give notification to the Bell Program Director about my plans.

I have read the above terms and conditions and agree to accept my placement in the **Roberts Wesleyan University and Bridge to Earning, Learning and Living Program**. I understand that I may be asked to leave **Roberts Wesleyan University and Bridge to Earning, Learning and Living Program** if I fail to follow the terms and conditions.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

Roberts Wesleyan University

Release and Waiver of Liability

I, _____ (participant) hereby release from liability, waive, discharge and covenant not to sue Roberts Wesleyan University and any of the officers, servants, agents and employees of the above-mentioned entities (hereinafter referred to as RELEASES) for any liability, claim and/or cause of action arising out of or related to any loss, damage or injury, including death, that occurs as a result of my participation in the Program arranged by Monroe BOCES 2 or CP Rochester to be held during my enrollment in the BELL Program at Roberts Wesleyan University. I understand that personally owned automobiles used in conjunction with any trips are not covered by Roberts Wesleyan University for property damage or liability.

I agree to indemnify and hold harmless the RELEASES whether injury is caused by my negligence, the negligence of the RELEASES or the negligence of any third party. I further agree that this Release and Waiver of Liability shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Release and Waiver of Liability shall be construed in accordance with the laws of the State of New York.

By signing this Release and Waiver of Liability, I state that I have read and understand the conditions set forth in this Release and Participation Agreement and that I agree to all conditions set forth herein, and that I sign this voluntarily.

_____ _____

Date Name (please print)

_____

Signature

_____

Signature of Parent or Guardian

NOTE: This Participation Agreement and Release and Waiver of Liability must be signed by both the participant and the participant's legal guardian if the participant is not of legal age.

Office Use Only

☐ **BELL/ BOCES 2 Program** **BELL /CP Rochester Program**

Agency Supervisor _____

Contact number _____

Other Information _____

ROBERTS WESLEYAN UNIVERSITY VOLLER ATHLETIC CENTER
DUAL ENROLLMENT WAIVER STATEMENT

I desire to voluntarily participate in the fitness and recreational activities at the Voller Athletic Center at Roberts Wesleyan University.

I know that any form of physical activity has inherent risk for illness or injury, ranging from minor debilitating injuries to actual life-threatening events. I am responsible for understanding my own physical limitations and operating within them at all times. I know I should not enter into any form of physical activity unless I am medically able.

I do swear that, to the best of my knowledge, I do not have any physical limitation that would put me at risk while participating in non-restricted activities at the Voller Athletic Center (Restricted Activities are listed below).

In the event that I develop physical problems or limitations, I agree to seek medical clearance from my personal physician before continuing any fitness or recreational activity at the Voller Athletic Center. I agree to abide by the principles stated above relative to my ability to safely participate in the recreational fitness activities at the Voller Athletic Center at Roberts Wesleyan University.

I know that it is my responsibility to use facilities and equipment only in the manner for which they are designed and that any misuse may cause injury to me and/or others. I also understand that I am liable for the cost of replacement or repair to equipment or facilities that have been damaged due to my misuse.

I assume all risks associated with any activity I pursue while on the premises of Roberts Wesleyan University including, but not limited to, falls, contact with other participants or objects, effects of heat and humidity, and damage to equipment or facilities, all such risks being known and appreciated by me. Having read this waiver and knowing these facts, I, for myself and anyone entitled to act on my behalf, waive and release Roberts Wesleyan University and their successors and representatives from all claims of liabilities of any kind arising out of my participation in the Voller Athletic Center activities.

Office Special notes:

□ An evaluation has been completed by the partner agency to determine student eligibility to utilize the VAC pool
___agency initial ____date

□ After review of the waiver, it has been determined the following VAC equipment will not be utilized:
___agency initial ____date

Comments:

Student's Printed Name: _____ **Date_____Time_____**

Student Signature: _____

Parent/Guardian Print Name: _____ **Date_____Time_____**

Parent/Guardian Signature: _____

Agency Representative's Printed Name: _____ **Date_____Time_____**

Agency Signature: _____

In the event of an emergency, please contact: _____

office use (date/initial) : Rec'd _____ Sent to VAC_____ Student File____ Program__BELL_____

VISUAL/AUDIO RELEASE FORM

I grant permission to Roberts Wesleyan University, its employees and agents, to take visual/audio images of me during my enrollment in the BELL Program. “Visual/audio images'' are any type of record of my visual image or voice, regardless of the methods of recording or the media in which recorded, such as but not limited to, photographic film, video, audio or digital tape, disc, drive or other electronic data storage device, drawings, paintings, caricatures, sculptures or other artistic representations or renderings, and any copies of imprints thereof; and written or auditory descriptions accompanying or related to such images or voice. Roberts Wesleyan University will not materially alter the original images. I agree that Roberts Wesleyan University owns the images and all rights related to them. The images may be used in any manner or media without notifying me, such as on college-sponsored websites, in College publications, promotions, broadcasts, advertisements, posters and theater slides, for educational, instructional, or promotional purposes. I waive any right to inspect or approve the finished images or any printed or electronic matter that may be used with them.

I release Roberts Wesleyan University and its employees and agents, including any person, firm or company authorized by the College, to publish and/or distribute a finished product containing the images, from any claims, damages or liability which I may ever have in connection with the taking/use of the images or printed material used with the images.

Please choose one of the following options:

□I am at least 18 years of age and competent to sign this release. I have read this release before signing. I understand its contents and I freely accept the terms.

Printed Name Signature Date

□I am at least 18 years of age and competent to sign this release. I have read this release, I understand its contents and I **DO NOT** accept the terms. I understand that it is my responsibility to notify any individual taking visual/audio images that I have not accepted/signed the release form and my images should not be used.

Printed Name Signature Date

FAFSA Disclaimer
CP Rochester Candidates Only

*Please note there is a cost for the BELL Program.

*All CP Rochester accepted students are required to fill out the FAFSA form no later than July 1st, 2026 for the first year and July 1st, 2027 for the second year.

*The University needs to see if the student is eligible for a full or partial PELL Grant.

*Each year the University and program partners look to see if any scholarships are available, however no scholarship can be offered to any student who did not complete the FAFSA form.

***If the FAFSA Form is not completed in a timely manner, the accepted student cannot start the program.**

By signing this FAFSA Disclaimer, I state that I have read and understand the conditions set forth and understand that the student cannot start the program unless the FAFSA is completed before the start of the semester.

_____ _____

Date Name (please print)

_____

Signature

_____

Signature of Parent or Guardian

CP Rochester
Authorization for the Use or Disclosure of Protected Health Information - HIPAA

As required by the Health Insurance Portability and Accountability Act of 1996, our agency may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to the Privacy Officer.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use and disclosure of the following health information pertaining to:
Individual's Name (print) _____ DOB _____ Male Female

Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including histories, notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing)*

_____ **Alcohol/Drug Treatment Information**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Reason for release of information:
- ☐ At request of individual
- ☐ To establish eligibility
- ☐ To facilitate program planning
- ☐ Other: _____

I authorize the following persons/provider to *make* these disclosures of my health information: **CP Rochester;** _____

I authorize the following persons/ provider to *receive* these disclosures of my health information: **CP Rochester;** _____

Signature of the patient or (if applicable) Guardian/Legal Representative: _____Date: _____

If not the patient, print name of person signing form: _____ Relationship: _____

Witness: _____Date: _____

By my signature:

- I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.
- I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Privacy Officer. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted on reliance on this authorization.
- I understand that this authorization will remain in effect until revoked by an authorized individual or the expiration of services.
- I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant of this authorization.

REVOCATION SECTION

I hereby revoke this authorization effective: _____

Individual Name: _____ DOB: _____

Signature of the patient or (if applicable) Guardian/Legal Representative: _____Date: _____

If not the patient, print name of person signing form: _____ Relationship: _____

Witness: _____Date: _____

Revised: 8/2017