



CLINICARE SCHOOLS

REFERRAL APPLICATION

Please complete and return to:

Jillian Christen, Director of Education
Joeann Tesar, Administrative Assistant
JTesar@clinicarecorp.com

Clinicare Alternative Day Schools
New Frontier Academy
Crossroads Academy
Eau Claire Academy

625 South Dousman
Prairie du Chien, WI 53821
608-326-6481

To include with Application:

- Individualized Educational Plan (IEP)
- BIP / FBA
- Health Plan
- Disciplinary Reports
- Report Card/Transcript

Other items needed prior to start:

- IEP Team Meeting
- School District Contract

Non-Discrimination Notice: Clinicare Alternative Day Schools will not discriminate in the provision of mental and behavioral health services to an individual based on the individual's race, color, sex, age, national origin, disability, religion, gender identity, or sexual orientation.



Student Name (First, Middle, Last): _____

Date of Birth: _____ **Age:** _____ **Current Grade:** _____

Male **Female** **Comment:** _____ **Current School District:** _____

Student Resides with: _____ **Requested Enrollment Date** _____

Transportation Plan (School District, Parents, other; morning, afternoon, sick, inclement weather):

Academic Plan: **Graduation** **Certificate of Completion** **Credit Recovery**

Behavior Goal(s) – what do we want the student to achieve?

1.

2.

3.

Academic Goal(s) – what do we want the student to achieve?

1.

2.

3.

Reintegration Plan:

Behavior(s)								
Aggression – Verbal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicidal Ideation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aggression – Physical	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self Harm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aggression - Property	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Refuse to go to School	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Huffing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Refusal while at School	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Theft	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Behaviors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Run Away	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arson	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually Active	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dress Code Violation	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please briefly explain/summarize any items checked "Yes"

Please list any other behaviors that the child has displayed:

Please list any out of home care services utilized (*mental health services, medication management, etc.*):

TEAM List			
Name	Title/Relationship		Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	City/State/Zip	Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	Invite to Meetings <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address	Day Time Phone	Cell Phone	Receive Reports <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Title/Relationship		Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	City/State/Zip	Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	Invite to Meetings <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address	Day Time Phone	Cell Phone	Receive Reports <input type="checkbox"/> Yes <input type="checkbox"/> No
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Email Address	Day Time Phone	Cell Phone	Receive Reports <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Title/Relationship		Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	City/State/Zip	Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	Invite to Meetings <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address	Day Time Phone	Cell Phone	Receive Reports <input type="checkbox"/> Yes <input type="checkbox"/> No