



A COLLEGE EXPERIENCE FOR A WORLD OF OPPORTUNITY

at Bethany Global University
6820 Auto Club Road Suite P, Bloomington, MN 55438
Phone: 952-994-4659

GENERAL APPLICATION FOR ADMISSION

This application should be completed in collaboration with the student and parent(s) or guardian(s). Please print or type legibly. If more space is required for responses, please attach an additional sheet. You are encouraged to keep a copy of the completed application for your reference.

STUDENT INFORMATION:

Name: Last First Middle Gender: Male Female

Mailing Address: Street City State Zip

Permanent Address: Street City State Zip

Home Phone

Cell Phone:

E-mail Address: Date of Birth\*: / /

Social Security Number (SSN)\*: / / Are you a resident of Minnesota? Yes No

\*The student's SSN and date of birth are confidential and protected under federal law from being disclosed to unauthorized parties. Your SSN will not be used as your student ID number. Your SSN will be safeguarded by The University and will not be displayed on official records or made available to others.

Is the student currently in foster care? Yes No

Is the student a U.S. Citizen? Yes No If no, is the student a Permanent Resident of the U.S? Yes No

Has the student applied for Vocational Rehabilitation services? Yes No

Does the student receive Vocational Rehabilitation services? Yes No

If yes, please list the VR counselor's name, address, email, and phone number:

Is the student receiving Social Security Insurance (SSI)? Yes No

Please explain:

How did you learn about Beyond Limits at Bethany College of Missions?

School Teacher/Counselor/Principal  
Internet Search

Flyer  
Young Life

Service Provider  
Other:

Conference/Fair

Agency

**FAMILY/GUARDIAN INFORMATION:**

Is the student his/her own guardian? \_\_\_ Yes \_\_\_ No

If no, are you the legal guardian of your student? \_\_\_ Yes \_\_\_ No

If no, have you or do you plan to apply to be his/her legal guardian? \_\_\_ Yes \_\_\_ No

Please identify the name of the primary contact for communication with BEYOND LIMITS?

What is the preferred method of communication? \_\_\_ Phone \_\_\_ E-mail

**Mother/Guardian:**

Name: \_\_\_\_\_  
Last First Middle

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

Employer/Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Father/Guardian:**

Name: \_\_\_\_\_  
Last First Middle

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

Employer/Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Siblings:**

How many siblings does the applicant have? \_\_\_\_\_

Please indicate the age, gender, and any other relevant information.

Age	Gender	Any Other Relevant Information

Why are you interested in Beyond Limits for this student?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the student's motivation for Beyond Limits.

Describe the student's attitude toward moving to college.

Describe the family's attitudes and concerns about the student moving away to attend college.

Describe any concerns you may have that would impact the applicant's ability to be successful at Beyond Limits.

Describe your preparations in assisting this student in making the transition to college life.

Please indicate if the student has stayed overnight away from his/her primary caregiver(s). (Please mark all that apply.)

Camp \_\_\_\_ School \_\_\_\_ Vacation \_\_\_\_ Other: \_\_\_\_\_

If yes, where did the student stay and for how long? \_\_\_\_\_

What level of supervision did the student have? (Please mark all that apply.) 24-hour One-to-one Small group

Were there any adjustment issues? No \_\_\_\_ Yes \_\_\_\_ If so, please explain. \_\_\_\_\_

Has the student used public transportation on his/her own to get to school or work? Yes \_\_\_\_ No \_\_\_\_

Does the student use a cell phone independently? Yes \_\_\_\_ No \_\_\_\_

Do you understand that the student will be required to have a cell phone in Beyond Limits? Yes \_\_\_\_ No \_\_\_\_

**EDUCATION HISTORY OF STUDENT:**

(Include primary, secondary, and any post-secondary experiences)

Name of School	Location	Description of Program—public, private, transition, etc	Years Attended	Completed Y or N

List the classes in which your student participated in the general education setting in the last two years of high school.

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Did the student have an associate/aide in the regular classroom? No \_\_\_ Yes \_\_\_ If yes, how many hours per week? \_\_\_\_\_

If yes, what type of support did the associate/aide provide? \_\_\_\_\_

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What type of special education assistance did the student receive outside of regular education classrooms?

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Please identify the type of instruction the student received in the resource classroom:

\_\_\_\_\_ One to one instruction                      Hours per week? \_\_\_\_\_

\_\_\_\_\_ Small group instruction                      Hours per week? \_\_\_\_\_

Please indicate the student's level of independence of completing homework assignments.

\_\_\_\_\_ Completely independent                      \_\_\_\_\_ Reviewing with adult                      \_\_\_\_\_ Direct assistance

Did your student have an IEP? No \_\_\_ Yes \_\_\_ (If so, Please submit the most recent copy.)

What was the student's primary category of disability? \_\_\_\_\_ Secondary? \_\_\_\_\_

Does your student have a 504 Plan? No \_\_\_ Yes \_\_\_ (If so, a copy must be submitted with the application materials.)

When did or will the student complete his/her high school education? (Month/Year) \_\_\_\_\_

Was a high school diploma awarded or, if the student has not graduated, is a high school diploma expected?

Yes \_\_\_ No \_\_\_

What type?      Standard                      Modified Standard                      Special                      Other \_\_\_\_\_

Was a certificate of attendance awarded or, if the student has not graduated, is a certificate expected?      Yes      No

**SUPPORT SERVICES\*:**

Please provide information on the support services your student received in school.

Type of Service:	Duration of Service:	Description of your student's accommodations:
Occupational Therapy		
Physical Therapy		
Speech and Language		
Assistive Technology		
Other:		

**PRIVATE THERAPUETIC SERVICES\*:**

Please provide information on the services your student received outside of school.

<b>Type of Service:</b>	<b>Duration of Service:</b>	<b>Does the service need to continue? Y or N</b>	<b>Reason the service needs to continue:</b>
Occupational Therapy			Occupational Therapy
Physical Therapy			Physical Therapy
Speech and Language			Speech and Language
Assistive Technology			Assistive Technology
Other:			Other:

\*BEYOND LIMITS Program fees and tuition do not include the cost of these services if continued.

Please indicate, in your opinion, the most effective learning strategies for your student:

- |              |            |                                 |
|--------------|------------|---------------------------------|
| Auditory     | Reading    | Visual Presentations/Organizers |
| Memorization | Repetition | Experiential Learning           |

Describe how your student compensates for learning or cognitive disabilities when managing a task.

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Describe any technology or assistive technology your student has used to assist in living, learning, or working.

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**EXTRACURRICULAR/VOLUNTEER ACTIVITIES:**

<b>Organization</b>	<b>Description of Activity</b>	<b>Dates</b>	<b>Hours/Week</b>

**EMPLOYMENT HISTORY:**

List all successful or unsuccessful employment experiences.

Name of Employer	Position and Job Responsibilities	Dates of Employment; Hours/Week	Reason for Leaving	Paid or Volunteer	Used a job coach? Yes or No

What accommodations were provided at work? (e.g., job coach, visual cues)

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To assist us with Practical Training placement, please describe the circumstances regarding any difficult work/volunteer experiences. \_\_\_\_\_

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**MEDICAL/DISABILITY HISTORY:**

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

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

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

Does the student have problems with incontinence? No \_\_\_ Yes\_\_\_, please explain: \_\_\_\_\_

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Does the student require any assistance in mobility? Yes \_\_\_ No \_\_\_

If so, does the student use any of the following mobility aids?

Prosthesis (specify: \_\_\_\_\_ )    Braces    Crutches    Cane    Manual Wheelchair    Motorized wheelchair/cart

Has the student ever had a seizure? No \_\_\_ Yes\_\_\_, please explain and provide dates and medical treatment:

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Please provide information on all medical conditions or diagnosis, other than common childhood illnesses.

Medical Condition:	Date of Diagnosis:	Description of the Medical Condition:	Does this impact the daily living of the student? Y or N

Please list any prescription medications student **is taking**:

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Please list any prescription medications student **has taken in the past** and explain the reason for stopping the medications:

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Please indicate the student's ability on each task below.

Medication Skills	Completely Independent	Minimal Assistance	Moderate Assistance	Complete Assistance	Not Applicable
Organizes medications daily or weekly					
Understands what medication to take at correct times daily					
Understands what medication to take in response to symptoms					

Does the student understand why he/she is taking each of his/her medications? \_\_\_Yes \_\_\_No

Dates of Hospitalization	Reason for Hospitalization

Please explain. \_\_\_\_\_

Please provide information about any hospitalizations the student has had. \_\_\_\_\_

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Has the student had any incidents of aggressive physical or verbal behavior? No \_\_\_ Yes \_\_\_, please list the year and nature of the situation(s). \_\_\_\_\_

Does the student have a history of legal violation, arrest, or probation? No \_\_\_ Yes \_\_\_, please list the date and nature of the situation(s). \_\_\_\_\_

Please describe the student's spiritual journey and why a Christian College program is important to them. \_\_\_\_\_

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 courses taken within Beyond Limits.

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

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 student's admission or registration. I understand that my student will not receive undergraduate credit for any courses taken within Beyond Limits.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date application submitted: \_\_\_\_\_

**Please also include the following with the completed application:**

- The most recent IEP or similar plan.
- The most recent educational evaluation report and/or most recent assessments that document the individual's present levels of ability/skills in the Academic, Adaptive/Functional Behavior, Social/Emotional/Behavior areas.
- The most recent Behavior Intervention or Behavior Support Plan
- Transcripts from high school and any postsecondary programs attended
- Letter of reference from clergy or youth pastor
- Physician statement regarding the suitability of program to meet the individual's health and safety needs
- If relevant to current needs, the most recent medical reports documenting physical and/or mental health status

*Additional documents may be requested if the selection committee determines that they are necessary to make a proper evaluation and decision.*



The Beyond Limits Leadership Team will review all applications for approval and letters of acceptance will be mailed as soon as possible and no later than July 1<sup>st</sup> of the current year.

### **Scholarships**

To apply for needs based scholarship, on separate sheet of paper, please tell us a bit about why you need a scholarship and how much you are anticipating you will be able to afford to pay. Please include an estimate of your annual income. We are trying at this point to spread our limited resources as far as we can and unless there is an extreme case we anticipate that scholarships