Washington Career Academy for the Deaf

Giving Deaf & Hard of Hearing
young adults the keys to unlock their potential!

Washington Career Academy for the Deaf (WaCAD)

Center for Childhood Deafness & Hearing Loss (CDHL)
611 Grand Blvd, Vancouver, WA 98661
(360) 696-6525 (V/TTY) / (800) 613-4228 / www.CDHL.wa.gov

TABLE OF CONTENTS

Send completed application along with a
$25 non-refundable application/processing fee to
WSD- 611 Grand Blvd, Vancouver, Wa 98661.
Refundable security deposit of $100 due upon acceptance to program.

Admission to and termination from the program is determined by the Washington Career Academy for the Deaf coordination team.

WaCAD PARTICIPANT INFORMATION

Are you: Deaf Hard of Hearing Deaf/Blind (Please Circle)

PARTICIPANT'S NAME	LAST	FIRST	MIDDLE
ADDRESS	STREET	CITY	STATE/ZIP
HOME PHONE NUMBER	TEXT PHONE NUMBER	EMAIL ADDRESS	
BIRTHDATE	AGE	GENDER	COUNTY OF RESIDENCE
EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER

PLEASE PLACE AN 'X' NEXT TO THE AREAS YOU NEED HELP WITH

☐	Balancing a checkbook/Budgeting Money	☐	Using public transportation
☐	Paying bills (rent, heat, water, garbage)	☐	Buying a car
☐	Looking for a job	☐	Taxes
☐	Applying for a job	☐	Organizational skills
☐	Grocery shopping	☐	Social Skills
☐	Cooking/preparing meals	☐	Self Advocacy

Are you a U.S. Citizen?	☐ Yes	☐ No
Do you have a Social Security Card?	☐ Yes	☐ No
Do you have a Permanent Resident Card?	☐ Yes	☐ No
Do you have a Green Card/Participant Visa?	☐ Yes	☐ No
Are you certified in CPR/First Aid?	☐ Yes	☐ No
Do you have a food handler's card?	☐ Yes	☐ No
Do you have a DVR Counselor?	☐ Yes	☐ No

If yes, name of DVR Counselor and telephone number:_____

Do you have guardianship? Yes No
If yes, Name of guardian:_____

Guardian signature required:_____
(If applicable)

Check Program (s) you may be interested in:

_____Community College _____Vocational/Technical _____Work Experience

WaCAD EDCUCATION/RELEASE OF INFORMATION

Name_____

High School Attended _____Fax Number_____

Agencies currently working with _____Fax Number_____

High School	Yes	☐	No	☐	Date:_____	Please attach copy of
GED	Yes	☐	No	☐	Date:_____	Please attach copy of certificate
Final IEP/Exit Report					Date:_____	Please attach copy of document

PLEASE SEND REQUESTED INFORMATION TO:
Toni Stromberg—WaCAD Coordinator
Washington Career Academy for the Deaf
611 Grand Boulevard
Vancouver, WA 98661
Fax: (360) 418-4358 Office: (360) 696—6525

Release of Information:

I, _____authorize the above listed school(s)/agencies to release records
please print

listed above.

All information shared will be treated in a confidential manner.

Participant Signature_____Date_____

Guardian's Signature_____Date_____
(if applicable)

PLEASE ANSWER THE FOLLOWING QUESTIONS

Participant Name:_____

1. Why do you want to join the Washington Career Academy for the Deaf?

2. What are two goals you have for your future?

(1)

(2)

WaCAD EMPLOYMENT HISTORY

Participant Name_____

EMPLOYMENT HISTORY

1. PRESENT OR LAST EMPLOYER		EMPLOYER'S ADDRESS
EMPLOYER'S PHONE NUMBER	YOUR TITLE	MONTHS & YEARS EMPLOYED IN THIS POSITION FROM _____ / _____ TO _____ / _____
TOTAL MONTHS EMPLOYED	AVERAGE HOURS/ WEEK	IMMEDIATE SUPERVISOR'S NAME
REASON FOR LEAVING		VOLUNTEER POSITION (YES/NO)
SPECIFIC DUTIES: _____ _____		

WORK EXPERIENCE

1. WORK EXPERIENCE IN WHAT SCHOOL		MONTHS & YEARS EMPLOYED IN THIS POSITION FROM _____ / _____ TO _____ / _____
AVERAGE HOURS/WEEK	TYPE OF WORK EXPEIRNCE	
EMPLOYER'S PHONE NUMBER	SUPERVISOR'S NAME	
SPECIFIC DUTIES: _____ _____ _____		
LIST ANY OTHER NON-PAID WORK EXPERIENCE OR VOLUNTEER POSITIONS: _____ _____ PLEASE LIST THE TYPES OF JOBS YOU ARE INTERESTED IN: _____ _____		

List three references that are not relatives or close friends. Teachers, employers, supervisors and/or group leaders are preferred. Be sure to inform your references they may be receiving a call.

Name_____

REFERENCE ONE			
NAME LAST	FIRST		RELATIONSHIP
ADDRESS STREET		CITY	STATE/ZIP
HOME PHONE NUMBER	WORK PHONE NUMBER		CELLULAR PHONE NUMBER
EMAIL ADDRESS			

REFERENCE TWO			
NAME LAST	FIRST		RELATIONSHIP
ADDRESS STREET		CITY	STATE/ZIP
HOME PHONE NUMBER	WORK PHONE NUMBER		CELLULAR PHONE NUMBER
EMAIL ADDRESS			

REFERENCE THREE			
NAME LAST	FIRST		RELATIONSHIP
ADDRESS STREET		CITY	STATE/ZIP
HOME PHONE NUMBER	WORK PHONE NUMBER		CELLULAR PHONE NUMBER
EMAIL ADDRESS			

WaCAD DISCLOSURE STATEMENT

This disclosure statement shall be completed and signed prior to acceptance into the WaCAD program

1. Have you ever been charged/adjudicated for violent offenses? _____ YES _____ NO

If yes, what for? _____ when?_____

By which police department_____

2. Have you been charged/arrested/adjudicated for any sexual offenses? _____ YES _____ NO

If yes, what for? _____ when?_____

3. Are you a registered sex offender? _____ YES _____ NO

If yes, what state? _____ what county?_____

4. Have you ever been suspended from school? _____ YES _____ NO

If yes, why?_____ when? _____

Where? (school name)_____

5. Have you ever been expelled from school? _____ YES _____ NO

If yes, why? _____ when? _____

Where? (school name) _____

6. Have you in the past or are you currently receiving Mental Health services? _____ YES _____ NO

If yes, what for? _____

Name of agency/clinic _____

7. Have you ever tried to harm yourself? _____ YES _____ NO

If yes, when? _____ What was the outcome? _____

8. Do you have a history of drugs or alcohol abuse? _____ YES _____ NO

If yes, what kind? _____ How often? _____

9. Have you ever been involved with Child Protective Services (CPS)? _____ YES _____ NO

If yes, explain _____

10. Do you have any ongoing needs related to severe emotional, behavioral or mental disorder? _____ YES _____ NO

If yes, explain _____

11. Do you have a psychiatric diagnosis by a psychiatrist or a provisional/suspected diagnosis by a mental health therapist? _____ YES _____ NO

If yes, explain_____

12. Do you need any special accommodations? _____ YES _____ NO

If yes, explain _____

I authorize the Washington Career Academy for the Deaf to conduct a background check on me. I certify under penalty of perjury, under the laws of the State of Washington that the above information is true and correct.

_____ _____

Date of Birth Maiden Name of other aliases used

_____ _____

Print Full Name Participant Signature

_____ _____

Date Place signed (city/state)

_____ _____

Date Guardians Signature (If applicable)

PARTICIPANT HEALTH RECORD/EMERGENCY INFORMATION

PARTICIPANT NAME: _____ **SEX:** _____ **DOB:** _____

Medical Emergency Permission	Yes	No	Restrictions
Local physicians and physicians contracted by CDHL may provide emergency treatment .			
My physician may be contacted as needed.			
I give permission for CDHL staff to act on my behalf when making emergency medical decisions should I be unavailable in an emergency.			
Nurses may convey medical information if needed that will be kept confidential, as they perceive beneficial, to staff working with participants.			

Medical History	
Health Conditions that are Life Threatening: Any condition that is life threatening, according to RCW 28A.210 Sec. I) requires that a emergency care plan be in place before the participant attends WaCAD.	Please note any health condition that are life threatening: (asthma, seizures, diabetes, allergies, etc.)
Please list all chronic and acute medical conditions or concerns.	
Please list allergies to medication, food, or insect sting:	
Special Diet:	Reason:
Activity Restriction:	Reason:
Medical Emergency Contacts:	
Insurance Information	
Name & Address of Insurance Company	Policy & Group Numbers/Union & Local

I am responsible for providing payment or medical insurance coverage for myself including medical expenses, evacuation and/or emergency transportation charges. Washington Career Academy for the Deaf does not provide medical insurance coverage and will not be held responsible for medical expenses under any circumstance.

Participant Signature _____ **Date:** _____

Guardian's Signature _____ **Date:** _____
(If applicable)