



Lakeside Academy

Parent/Guardian Name _____

Date: _____

Child's Permanent Address:

Social Security Number: _____ - _____ - _____

Street: _____

City, State, Zip: _____

Phone: (h) _____ (c) _____

Email: _____

Legal Resident Of:

State: _____

County: _____

Child's First Name: _____

Gender: Male Female

Middle Name: _____

Last Name: _____

DOB: ____/____/____ Age: _____ Height: _____ Weight: _____

Nickname(s) if any: _____ Written/Verbal Language: English, Other _____

Does Your Child Have Any Relatives Or Friends Currently In Our Program? No Yes; Who? _____

Has Your Child Previously Been In Our Program? Yes No How Many Years Ago? _____

Custody Status: Parents Married Joint Legal Father- Sole Mother-Sole Legal Guardian

Adopted: Yes No Citizenship: United States Other _____

Race: American Indian Asian Black Hispanic Multi Racial White Other _____

Parent's Religious Affiliation: _____ Child's Religious Affiliation: _____

My Child Mainly Needs Help With: (Check All That Apply) Behavior Alcohol/Drug Use School

Mental Health Other: _____

Has your child ever been in a Residential Program? Yes No

Prior Residential Program: (list the most recent program your child has been in)

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Program: ____/____/____ to ____/____/____

Did he complete the program? Yes No

Reason for discharge if not completed: _____

For Admission Use only:

INSURANCE INFORMATION

Does your child have medical insurance? Yes No If yes, please provide the following information:

Insurance Provider: _____

Member ID Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth ____/____/____

Address: _____

Group Number: _____

City: _____ State: _____ Zip: _____

Provide Phone: () _____ - _____

IMPORTANT NOTE: This is for supplemental medical needs while in the program. (i.e. doctor's visits, prescriptions, etc.) Not all insurance plans cover out-of-state clinics and services. If deemed necessary, a student may need to be seen by a local clinic while in the program. If insurance does not cover the medical visit, parents will be billed directly by the clinic for services.

____ Initial Initial



STRENGTHS AND ASSETS INVENTORY

Please check all that apply:

- | | | | |
|--------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> accepting | <input type="checkbox"/> helpful | <input type="checkbox"/> social | <input type="checkbox"/> forgiving |
| <input type="checkbox"/> agreeable | <input type="checkbox"/> honest | <input type="checkbox"/> spiritual | <input type="checkbox"/> free |
| <input type="checkbox"/> analytical | <input type="checkbox"/> humble | <input type="checkbox"/> steady | <input type="checkbox"/> friendly |
| <input type="checkbox"/> approving | <input type="checkbox"/> industrious | <input type="checkbox"/> straight-forward | <input type="checkbox"/> generous |
| <input type="checkbox"/> assertive | <input type="checkbox"/> involved | <input type="checkbox"/> thoughtful | <input type="checkbox"/> gentle |
| <input type="checkbox"/> attentive | <input type="checkbox"/> kind | <input type="checkbox"/> tolerant | <input type="checkbox"/> good listener |
| <input type="checkbox"/> bold | <input type="checkbox"/> lawful | <input type="checkbox"/> trusting | <input type="checkbox"/> giving |
| <input type="checkbox"/> careful | <input type="checkbox"/> loving | <input type="checkbox"/> unassuming | <input type="checkbox"/> guilt-free |
| <input type="checkbox"/> cautious | <input type="checkbox"/> modest | <input type="checkbox"/> venturesome | <input type="checkbox"/> rational |
| <input type="checkbox"/> cheerful | <input type="checkbox"/> nice | <input type="checkbox"/> warm | <input type="checkbox"/> realistic |
| <input type="checkbox"/> concerned | <input type="checkbox"/> open | <input type="checkbox"/> willing | <input type="checkbox"/> relaxed |
| <input type="checkbox"/> confident | <input type="checkbox"/> open-minded | <input type="checkbox"/> witty | <input type="checkbox"/> reliable |
| <input type="checkbox"/> considerate | <input type="checkbox"/> optimistic | <input type="checkbox"/> permissive | <input type="checkbox"/> romantic |
| <input type="checkbox"/> content | <input type="checkbox"/> organized | <input type="checkbox"/> persistent | <input type="checkbox"/> selfless |
| <input type="checkbox"/> controlled | <input type="checkbox"/> outgoing | <input type="checkbox"/> playful | <input type="checkbox"/> self-sufficient |
| <input type="checkbox"/> cooperative | <input type="checkbox"/> patient | <input type="checkbox"/> Polite | <input type="checkbox"/> sensitive |
| <input type="checkbox"/> decisive | <input type="checkbox"/> peaceful | <input type="checkbox"/> dependable | <input type="checkbox"/> extroverted |
| | | <input type="checkbox"/> disciplined | <input type="checkbox"/> flexible |

Include any additional positive traits here:

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PHYSICAL HEALTH

Medical History: (Check all that apply to child's current and past conditions)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Gastric Bypass Surgery | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Head Trauma/TBI | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Attack/Stroke/Condition | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STI/STD |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |

Does your child have any current medical concerns? If yes, please be specific: _____

Primary Physician's Name: _____

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

For Admission Use Only:

Is your child allergic to any medications? Yes No If Yes, what medications? _____

Is your child being treated with prescribed narcotics/benzodiazepine/opiate/prohibited medications? Yes No

If Yes, what medications? _____

(Applicants on these types of medications or ingesting any of the above will need to complete the taper regimen prior to admission or switch to approved medications under doctor supervision.)

Special Needs:

Does your child have any type of disability? Yes No Type: _____

Does your child have any chronic conditions? Yes No Type: _____

Does your child have any medical restrictions? Yes No Type: _____

Does your child have any other type of special needs? Yes No Type: _____

Does your child have any allergies? Yes No Type: _____

Does your child require a special diet? Yes No Type: _____

****Lakeside Academy does not make special dietary accommodations.***

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MENTAL HEALTH

Mental Health History: (Only check the following conditions if diagnosed by a professional.)

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Reactive Attachment Disorder |
| <input type="checkbox"/> Anti-Social Personality Disorder | <input type="checkbox"/> Homicidal Tendencies/Thoughts | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Anxiety Disorder/Panic Attacks | <input type="checkbox"/> Intermittent Explosive Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Autism /Asperger's | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Self-Injury |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Narcissistic Personality Disorder | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Suicide Ideation (thoughts) |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Toileting/Incontinence Issues |
| <input type="checkbox"/> Dissociative Identity Disorder | <input type="checkbox"/> PTSD/Trauma | <input type="checkbox"/> Other Diagnosed Disorder_____ |

Has your child thought about, or attempted suicide in the past 3 months? Yes No If yes, how long ago: ____

Are you aware of your child having access to or viewing "The Dark Web?" Yes No

Primary Psychiatrist/Psychologist: _____

Clinic: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

For Admission Use Only:

Mental Health Medications Currently Prescribed:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		

Has the student had a diagnostic assessment in the last 6 months? Yes No

(If yes, please include this with the application.) If a DA is not provided, an assessment will be completed upon admission. This may be covered by your insurance company depending on your plan's coverage.

Assessors Name: _____ **Clinic Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Office Phone: _____ **Fax:** _____ **Email:** _____

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LEGAL ISSUES

Is your child currently on probation or parole? Yes No State/County: _____
 Does your child currently have any court cases pending? Yes No State/County: _____
 Is your child currently under investigation for anything? Yes No State/County: _____
 Does your child currently have any outstanding warrants? Yes No State/County: _____

Has your child ever been convicted of a violent crime? Yes No If yes, please list each conviction and date:

Has your child ever been convicted of a sex related crime? Yes No If yes, please list each conviction and date:

Is your child currently facing charges for a violent or sex related crime? Yes No If yes, please describe fully:

Is your child required to register as a sexual or predatory offender? Yes No
 If yes, what Level? 1 2 3 Is your child required to "Notify the Community" or police department? (please circle)

Probation Officer's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

For Admission Use Only:

Attorney's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

For Admission Use Only:

Case worker: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

For Admission Use Only:

EMERGENCY CONTACTS

Primary Contact Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Secondary Contact Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

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CHEMICAL DEPENDENCY

Check all known substances used:

- | | |
|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Methamphetamines |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Over the counter medication |
| <input type="checkbox"/> Ecstasy (i.e. MDMA, Molly) | <input type="checkbox"/> Prescription pills |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Inhalants (i.e. aerosol sprays, spray paint, etc.) | <input type="checkbox"/> Synthetic drugs (i.e. K2, Spice, Bath Salts) |
| <input type="checkbox"/> LSD/Acid | <input type="checkbox"/> Tobacco/cigarettes/chew |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Vaping / eCigs |

If Child Is Abusing Substances, Last Date Of Use? _____

Substance(s) Used: _____

Previous Treatment for Substance Abuse:

In-Patient Treatment (list the most recent program your child has been in)

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Program: ____/____/____ to ____/____/____

Primary Reason for Treatment: _____

Did he complete the program? Yes No

Out-Patient Treatment (list the most recent program your child has been in)

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Program: ____/____/____ to ____/____/____

Primary Reason for Treatment: _____

Did he complete the program? Yes No

Please submit copies of the following with this application:

- C/D Assessment and Progress Notes
- Treatment Recommendations
- Continuing of Care Recommendations
- Discharge Summary

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SCHOOL / EDUCATIONAL

Student's Name _____

Date of Birth: _____

*****To expedite your son's enrollment in school at Lakeside Academy, please get a copy of his transcripts from his current school and include it when you submit this application.**

1. Is your child currently enrolled in school? Yes No
2. Is your child home-schooled Yes No
3. Does your child read and write English at a 5th grade level or above: Yes No
4. What is his current grade level? 9th 10th 11th 12th Other_____
 - a. Are your son's credits on course for graduation and include transcripts requirement so that course can be assigned by orientation date. Yes No
5. Are they on an IEP (Individualized Education Plan/Program)? Yes No
6. Do they have a 504 accommodation? Yes No
7. To your knowledge is your son on an RTI (Response to Intervention) plan? Yes No

*****If you answered "YES" to questions 5, 6, or 7, please include copies of this documentation.**

Previous School Attended:

School Name

Address

City

State

Zip Code

Phone Number

Fax Number

Records Coordinator E-mail Address

IN ACCORDANCE WITH REVISED FEDERAL AND STATE STATUTES, PERMISSION OF THE PARENT OR ADULT IS NO LONGER REQUIRED WHEN RECORDS ARE REQUESTED BY AUTHORIZED SCHOOL PERSONNEL.



Lakeside Academy

Voluntary Compliance with Faith Based Activities

Lakeside Academy is a faith-based program that is based upon Christian principles and practices. If you do not want your son to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better meet your needs.

If you object to the spiritual education model utilized by Lakeside Academy and object to the religious character of this organization, Federal law gives you the right to a referral to another provider. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to Lakeside Academy, I understand the following (please initial each line):

- _____ My child will participate in daily devotions, Bible reading, and prayer.
- _____ My child will participate in lecture classes, individualized study courses, group counseling, individual counseling, and other program components that are based on Christian principles.
- _____ My child will attend church services when scheduled.
- _____ If offered the opportunity to partake in communion or water baptism participation is voluntary.
- _____ If I object to the religious nature of this program and its requirements, I will notify the Center Director and receive a referral to another program of my choosing.

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the Lakeside Academy program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

I have spoken with my child about placing him/her in a faith-based program.

Parent's Signature

____/____/____
Date

Parent's Signature

____/____/____
Date

Print Child's Name: _____



Lakeside Academy

Full Disclosure to Minor

Lakeside Academy (LA) holds the position that full disclosure is the best method for placing a minor in our program.

While most teenagers will not be happy about having to relocate to a new living situation, LA still requires a minimum awareness of the decision to be placed at LA. The minor should be informed in advance of the timeframe for placement, including the specific time and day for intake.

Additionally, the following items must be presented to the minor prior to intake:

- Lakeside Academy is Faith-based/Christian program
- Program duration can be up to twelve months, with a minimum commitment of six months

3rd Party Transportation Services

- Admission by a transport service is allowed on a case-by case basis
- Although transport services can be expensive, this may be an option to bring your son to LA; however, the same full disclosure policy still applies
- If a minor arrives via transport without a reasonable amount of compliance upon arrival, the parent/guardian will be responsible for making immediate arrangements for the minor to return home

I understand these expectations and hereby acknowledge acceptance of these terms. I also acknowledge that if a minor arrives at LA without prior knowledge, LA retains the right to rescind acceptance into the program.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Print Student's Name



Lakeside Academy

Parental Release of Liability Agreement

I/We, _____, parent(s), guardian(s), or conservator(s) of

_____, a minor child, born on _____, hereby agree that he/she can enroll in Lakeside Academy (LA) and Minnesota Adult and Teen Challenge (MnTC), a therapeutic boarding school. I/We further agree that I/we relieve LA/MnTC, its staff, employees, students, and board members from any responsibility or liability for any damages to him or his property during his residence at LA/MnTC or during any related travel and/or activities. I/We also agree to release, hold harmless, and relinquish all rights to pursue any cause of action whatsoever against LA/MnTC, its staff, employees, students, and board members if a resident voluntarily leaves LA/MnTC or for any damages incurred during his residence. I further acknowledge that LA/MnTC is not a lock down facility and that in the event my child runs away from the facility, LA staff will contact Wright County Sherriff Department to report the minor child as a runaway.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Medical, Surgical, and Dental Permit

Lakeside Academy may provide emergency services anytime the parent(s), guardian(s), or emergency contact person(s) cannot be reached, when, in the opinion of the attending, duly qualified physician, said services are deemed necessary or advisable. I/we consent to the administration of whatever anesthetics are advisable or necessary and I/we agree to be solely responsible for payment of any and all medical or dental services obtained.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

APPLICANT'S STATEMENT

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, my child may be discharged from the Lakeside Academy program. Furthermore, I understand that Lakeside Academy is a Christian, faith-based program and that I have made a free and independent choice to enroll my child. I understand that other program options are available to me and I have had an opportunity to request a referral. I agree that that I will settle any and all previously asserted claims, disputes or controversies arising out of or relating to my application, participation in and discharge from the Lakeside Academy program with Lakeside Academy by final and binding arbitration in accordance with the applicable American Arbitration Association rules of arbitration in effect on the date that arbitration is requested by either me or Lakeside Academy. I agree that all administrative costs of arbitration shall be divided equally among the parties.

Please initial indicating that you have received, read, and agree to abide by the following documents:

_____ Lakeside Academy Student Handbook

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



Program Costs: Enrollment, Tuition, Deposits, and Other Fees

Down Payment for Bed Reservation

Initial payment to TADS due prior to the admission date: \$7850 w/insurance or \$10,360 w/out insurance and is non-refundable. The fee covers all aspects of the intake process including room & board for up to one month. All services covered in the monthly tuition are also included in the enrollment fee.

Cost of Program

Standard tuition covers: room & board (breakfast, lunch, dinner, and snack daily), 24/7 direct care staff, academic support for online school (classroom teacher), daily vocational experience (i.e. woodshop, welding, automotive, etc.) on-site recreational activities, Lakeside Academy Cares app, individual and group counseling sessions and other basic behavioral groups.

Damage Deposit: \$500.00 (Please bring cash, check or money order on day of admission)

A damage deposit is required for all applicants at the time of admission. Money from this deposit will be used to repair or replace damaged property caused by the student. Parents/guardians are required to replace money used from the damage deposit so that a \$500.00 deposit is maintained at all times. A minimum charge of \$50 will be charged per incident. Upon discharge, the damage deposit minus any damage expenses will be refunded.

Personal Needs Money: \$300.00 (Please bring cash, check or money order on day of admission)

The client personal account in which the client's parent places money in to, is not for them to use at their leisure. The account is used for incidentals, haircuts, sometimes rec events as well as reward center.

TADS Billing and Tuition Management: \$45.00 (non-refundable)

This is a one-time fee required to set up tuition payment for the program. NOTE: if you use a credit card, TADS does assess an additional processing fee of 3%.

Minimum Due At Time of Admission:

Enrollment Fee: **\$7850 w/insurance or \$10,360 w/out insurance**

Damage Deposit: **\$500.00**

Client Personal Needs Money **\$300.00**

TADS Fee: **\$45.00** (paid directly to TADS)

**Families that choose to pay the full program deposit up front
will receive a 20% discount**

Initial Initial



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Program Costs: Tuition, Deposits, and Other Fees (cont.)

Program Fee Philosophy

It is common for boarding school and treatment programs to exceed \$150,000, LAKESIDE ACADEMY will strive to keep your total yearly (12 months) out of pocket expenses down so that they do not exceed the amount of your deposit. Even if the services provided to your child greatly exceed your deposit, LAKESIDE ACADEMY will work with your insurance company and will utilize scholarships, grants, other third-party payers, debt forgiveness, etc. to accomplish its commitment to cap your total out of pocket expenses.

LAKESIDE ACADEMY offers a discount if you choose to pay the entire deposit at the time of your son’s admission. We do understand that this may not be a feasible option for your family so LAKESIDE ACADEMY offers a 12 month payment plan. The first payment will include the first month and a non-refundable deposit. This amount is due at the time of admission.

The details of the program fees and payment plan will be discussed in more detail with LAKESIDE ACADEMY’S admission staff.

Cost of Program

LAKESIDE ACADEMY will have two (2) cost plans: (1) with insurance and (2) without insurance. Within each of these plans, families will be able to receive a discount for full payment at time of admissions or commit to making payments over 12 months.

Cost of program with insurance:

Payment is made in full receiving 20% discount	\$38,884
Payment is made over 12 months	\$48,605

Cost of program without insurance:

Payment is made in full receiving 20% discount	\$50,880
Payment is made over 12 months	\$63,600

Refund Policy

Any excess funds or deposit monies remaining in the client/student’s account will be refunded within 30 days of the child’s discharge from the program. The refunds are calculated based on the balance of unpaid services.

I have read the statements above regarding the financial obligations of enrolling my son at Lakeside Academy and agree to these terms.

Parent/Guardian signature

Date

Parent/Guardian signature

Date