



Marion's Way Preschool Application

Summer 2021

Applications are due by April 20, 2021

Purpose and Philosophy:

Marion's Way Preschool is an intensive summer preschool program for children who are deaf or hard of hearing incorporating a language-rich environment and instruction with a focus on developing listening and spoken language skills. Theme-based learning experiences incorporated into language, cognitive, and literacy activities for children will support social, emotional, and pre-academic development. Technology will optimize auditory access. Parent participation and training will support carryover of these skills to home and family environments. Applications will be considered on a first come first serve basis based on eligibility requirements.

Eligible Students:

- Ages 3-5
- Deaf or hard-of-hearing
- No significant additional disabilities or challenges that impact acquisition of spoken English
- English spoken language levels of 2 years-5 years
- Participation is **required** for pre & post speech/language, learning, and hearing assessments at the Marion Downs Center (MDC). This is 2 or 3 visits each 1.5 hours in length.
- Parents participate in all parent information sessions
- Referral from parent, teacher, early intervention provider, speech-language pathologist, or audiologist
- Release of Information from medical and school audiologist also needed

Schedule and Location:

- The 6-week program meets on Tuesday, Wednesday and Thursday mornings from June 15th to July 29th. Note there will be no class the week of July 4th.
- Assessments are completed in May/early June at the MDC (4280 Hale Parkway, Denver 80220)
- The Preschool meets at the Anchor Center (2550 Roslyn Street, Denver 80238)

Tuition and Scholarships:

- Tuition is \$2,200 and includes 6 weeks of preschool and 3 parent information sessions
- Participation will not be limited by family's financial resources
- Scholarships are available

_____ I speak to my child. I do not use sign language.

_____ I typically speak to my child. I occasionally use some sign language.

_____ I typically speak AND sign to my child. I try to sign most or all of the time when I talk.

_____ I typically sign to my child WITHOUT speaking.

CURRENT SCHOOL AND THERAPY:

NOTE: Answer each of the questions in this section in relation to the academic year your child just completed.

Name of School: _____ School District: _____

Name of Classroom Teacher: _____

Name of Deaf Educator or Speech Pathologist: _____

Phone Number: _____ Email: _____

Please complete the following table indicating how many hours/minutes per week that your child is in each type of educational setting:

| Type of Intervention | Hours | Minutes |
|--|-------|---------|
| Class primarily for deaf/hard-of-hearing children | | |
| Class for children with a variety of special needs | | |
| Class primarily for hearing children | | |
| Other, please describe: _____ | | |

Check the sentence that best describes how the child's teacher communicates with your child MOST of the time.

_____ The teacher speaks to my child. She/He does not use sign language.

_____ The teacher speaks to my child. She/He occasionally use a little bit of sign language.

_____ The teacher typically speaks AND signs to my child. She/He tries to sign most/all of the time when speaking.

_____ The teacher typically signs to my child WITHOUT speaking.

Does your child receive speech or auditory therapy outside of school? Yes _____ No _____

If YES, amount of time per week: _____ Therapist's name(s): _____

Phone Number: _____ Email: _____

CHILD'S OTHER SPECIAL NEEDS/CONDITIONS: (Please check all that apply.)

_____ No other disabilities

_____ Vision problem/impairment

- | | |
|--|--|
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Cerebral palsy (CP) | <input type="checkbox"/> Emotional/Behavioral problem |
| <input type="checkbox"/> Specific Learning disability (LD) | <input type="checkbox"/> Motor problem |
| <input type="checkbox"/> Developmental/Cognitive delay | <input type="checkbox"/> Central processing disorder |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Cleft lip/palate |
| <input type="checkbox"/> Balance disorder | <input type="checkbox"/> Sensory/Motor integration problem |
| <input type="checkbox"/> Other disability. Please explain: _____ | |

Is your child receiving any intervention services for additional special needs/conditions (other than hearing loss)?
 Yes _____ No _____

If Yes, name and type of program:

Contact Person _____

Email Address: _____ Phone: _____

Is your child able to attend the full six-week program? Yes _____ No _____

Are you able to bring your child to the Marion Downs Center to do pre and post speech/language/hearing/learning assessment? Yes _____ No _____

Will you be able to attend 3 parent information sessions during the program and participate in your child's intervention?
 Yes _____ No _____

What else would you like us to know about your child?

Some audiology and speech language services are included as part of Marion's Way Preschool. Evaluations and some services will be billed to your insurance. If these are not benefits covered by your insurance, financial aid is available.

Insurance Provider Company Name _____

Medicaid

ID # _____ Policy Holder _____

Who referred this child to Marion's Way Preschool?

Name: _____

Phone number: _____

How did you hear about Marion's Way Preschool? _____

Please attach a copy of your child's most recent IEP documents, including testing results and audiogram.
 ** This information needs to be included with your application for it to be processed.
 ** Please complete release of information included in this packet.

