



COMMUNITY SERVICES FOR AUTISTIC ADULTS AND CHILDREN

APPLICATION FOR SERVICES

I. Attach a photograph of the applicant here.

Date of Application: _____

Please check services applied for:

- Adult Residential Services
- Adult Supported Employment/Vocational
- Community School of Maryland
 - Dayschool
 - Residential School
- Support Services

II. Applicant Name: _____

D.O.B: _____ Social Security Number: _____ M.A. #: _____

Address: _____

Telephone Number: _____

III. Name of Parent/Guardian: _____

Address: _____

Phone Number (Home) _____

(Business) _____

IV. Name of Person Completing Form (if different from above): _____

Address: _____

Phone Number (Home) _____

(Business) _____

V. Applicant's Diagnosis Identified on Most Recent Evaluation:

_____	_____	_____
Diagnoses	Name of Evaluator	Date
_____	_____	_____
Diagnoses	Name of Evaluator	Date
_____	_____	_____
Diagnoses	Name of Evaluator	Date
_____	_____	_____
Diagnoses	Name of Evaluator	Date
_____	_____	_____
Diagnoses	Name of Evaluator	Date

VI. Applicant's IQ Score Obtained on Most Recent Evaluation:

_____	_____	_____	_____
Test	Evaluator	IQ Score	Date of Evaluation

VII. Program History. Is applicant presently receiving educational, residential or vocational services? ___ Yes ___ No

If Yes:

Name of Agency: _____

Type of Service Rendered: _____

Address: _____

Phone Number: _____

List all previous educational, residential or vocational services received (use back of page if additional space is required).

_____	_____	_____	_____
Name of Service	Type of Service	Date Service Received	Staff Ratio
_____	_____	_____	_____
Name of Service	Type of Service	Date Service Received	Staff Ratio
_____	_____	_____	_____
Name of Service	Type of Service	Date Service Received	Staff Ratio

Name of Service	Type of Service	Date Service Received	Staff Ratio
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Name of Service	Type of Service	Date Service Received	Staff Ratio
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Name of Service	Type of Service	Date Service Received	Staff Ratio
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VIII. List Applicant's Work Experience.

Employer

Position Held	Dates Employed	Date of Separation
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Reason for Separation

Employer

Position Held	Dates Employed	Date of Separation
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Reason for Separation

Employer

Position Held	Dates Employed	Date of Separation
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Reason for Separation

Employer

Position Held

Dates Employed

Date of Separation

Reason for Separation

IX. Has applicant applied to the Division of Vocational Rehabilitation: Yes No

Name of DVR Counselor: _____

Phone Number: _____

Has applicant had a vocational evaluation: No
 Yes _____

(Date of Evaluation)
(Please attach copy)

X. Has applicant applied for Autism Waiver? No Yes

XI. Has applicant applied for DDA funding? No Yes

XII. Medical/Dental. List any specific health problems (diabetes, seizures, hearing impairment, dental problems, etc.)

Condition

Treatment Required (if any)

Condition

Treatment Required (if any)

Condition

Treatment Required (if any)

Condition

Treatment Required (if any)

Condition

Treatment Required (if any)

Is applicant currently taking behavior-modifying medication? No Yes

If Yes:

Name of Medication

Dose

Purpose of Medication

Name of Medication

Dose

Purpose of Medication

Name of Medication	Dose	Purpose of Medication
Name of Medication	Dose	Purpose of Medication
Name of Medication	Dose	Purpose of Medication

III. Name of Psychiatrist/Physician Prescribing Medication: _____

IV. Socialization/Behavior. Has the applicant displayed any of the following types of behavior problems in the past 5 years?

a. Aggression ___ Yes ___ No
 (If yes, please describe these behaviors and how frequently applicant engages in behaviors, i.e., hitting, biting, kicking.)

b. Self-Injurious ___ Yes ___ No
 (If yes, please describe these behaviors and how frequently applicant engages in behaviors.)

c. Difficulty Sleeping ___ Yes ___ No
 (If yes, please describe behavior and how frequently it occurs.)

- d. Wandering/Running Away/Darting ___ Yes ___ No
(If yes, please describe behaviors and if special supports are needed in vehicles due to, i.e., attempts to jump from moving vehicle or interfere with driver or controls.)

- e. Eating Inedible Items ___ Yes ___ No

- f. Destruction of Property ___ Yes ___ No

- g. Voice Volume ___ Yes ___ No
(If yes, i.e., yelling, screaming, prolonged episodes of crying, loud vocalizations, please describe.)

- h. Other Problem Behaviors ___ Yes ___ No

V. Financial. List applicant resources:

	Receiving Benefits	Have Applied, Awaiting Benefits	Have Not Applied	Amount of Benefits
1. SSI				
2. Medical Assistance (Medical)				
3. SS (ADC)				
4. VA Benefits				
5. Section 8 Rental Supplemental				
6. Food Stamps				
7. Other				

VI. Has applicant been declared incompetent by court? (Guardianship) ___ Yes ___ No
(If yes, attach court document.)

a. Were there any problems during pregnancy? Were any medications used? Describe.

b. Were there any problems with labor and delivery? Describe.

c. Were there any early childhood illnesses or injuries? At what age? Describe.

d. When were motoric developmental milestones (toilet training, sitting, standing, walking) achieved?

e. Did the child develop functional speech? At what age? Describe child's methods of communication.

f. Did child ever appear to be deaf or blind? At what age?

g. Did child make eye contact with other people? At what age? Describe.

h. Did child enjoy cuddling? At what age? Describe.

i. Did child respond differently to attention from strangers than from family? At what age? Describe.

j. Was child unusually quiet or fussy? At what age? Describe.

k. Did child play with toys appropriately? At what age? Describe.

l. Did child play with other children? At what age? Describe.

m. Did child appear withdrawn or remote? At what age? Describe.

n. At what age did child engage in self-stimulatory behavior (i.e., rocking, finger-flicking, spinning objects, making sounds.) Describe.

o. At what age did child engage in self-injurious behaviors? Describe.

p. At what age did child engage in aggressive behaviors? Describe.

VII. Attach a copy of the applicant's current Individual Program Plan (IPP) or Individual Education Plan (IEP).

VIII. Attach most recent medical, psychological, educational and speech/language evaluations. (Record will be incomplete and admissions actions will be deferred until these records are received.)

IX. Is there any special equipment or modifications needed in the home, school or employment programs?

X. Complete the following Caregivers form and return application.
Return completed application to:

Community Services for Autistic Adults and Children (CSAAC)
8615 East Village Ave
Montgomery Village, MD 20886

Telephone: (240) 912-2220
Facsimile: (301) 926-9384