Reset Form.

csaac
enhancing the lives of individuals with autism

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
- ☐ Adult Day-Hab (CLS/CDS) / Vocational
- ☐ Community School of Maryland
  - ○ Dayschool
  - ○ Residential School

II. Applicant Name:

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

Address:

Telephone Number:

Name of Parent/Guardian:

Address:

Phone Number (Home)

(Business)

Email Address

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

Address:

Phone Number (Home)

(Business)

Email Address

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

Name of Service Type of Service Date Service Received Staff Ratio

Name of Service Type of Service Date Service Received Staff Ratio

VIII. List Applicant's Work Experience.

Employer

Position Held Dates Employed Date of Separation

Reason for Separation

Employer

Position Held Dates Employed Date of Separation

Reason for Separation

Employer

Position Held Dates Employed Date of Separation

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

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 aggressive behaviors? Describe.

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

VIII. Please provide proof of applicant's age, (for CSAAC Adult Services programs, applicant must be 21 y/o at start of services)

IX. 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.)

X. Attach Matrix Score (sent directly from CCS company email account, or alternatively on CCS company letterhead).

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

Return completed application to:

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

Email: sthomas@csaac.org
Telephone: 240-912-2220
Facsimile: 240-813-1006