COMMUNITY SERVICES FOR AUTISTIC ADULTS AND CHILDREN

(Please complete in blue or black ink.)

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 ○ Day school ○ Residential School

II. Applicant Name: _____

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

Address: _____

_____

Telephone Number: _____

III. 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

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

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 aggressive behaviors? Describe.

_____
_____

VII. Attach a copy of the applicant's current Individual Program Plan (IPP), Individual Behavior Plan (IBP), Individual Education Plan (IEP) and Student Health Passport.

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: health insurance information, immunization records, physical exam (current physical within 12-months, must include medications, any food/drug allergies), dental. If seen by a specialist, please provide the last report (i.e. Cardiology, Dermatology, Allergist, etc.).

X. Attach most recent psychological, psychiatric (must be within 6 months), educational and speech/language evaluations.

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

Record will be incomplete, and admissions actions will be deferred until these records are received.

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

_____
_____
_____
_____

Return completed application to:

Chynah Brown
Adult Admissions Specialist
Community Services for Autistic Adults and Children (CSAAC)
8615 East Village Ave
Montgomery Village, MD 20886

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