



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
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Diagnoses	Name of Evaluator	Date
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Diagnoses	Name of Evaluator	Date
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Diagnoses	Name of Evaluator	Date
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Diagnoses	Name of Evaluator	Date
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VI. Applicant's IQ Score Obtained on Most Recent Evaluation:

Evaluator	IQ Score	Date of Evaluation	Test
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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
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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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_____ 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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_____ of Service	_____ Type of Service	_____ Date Service Received	_____ Staff Ratio	_____ Name
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VIII. List Applicant's Work Experience.

Employer

_____ Dates Employed	_____ Date of Separation	_____ Position Held
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Reason for Separation

Employer

Dates Employed Date of Separation _____ Position Held

Reason for Separation

Employer

Dates Employed Date of Separation _____ Position Held

Reason for Separation

Employer

Dates Employed Date of Separation _____ Position Held

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