COMMUNITY SERVICES FOR AUTISTIC ADULTS AND CHILDREN

(Please complete in blue or black ink.)

APPLICATION FOR SERVICES

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

1. Applicant Name: _____

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

Address: _____

_____

Telephone Number: _____

2.

Name of Parent/Guardian: _____

Address: _____

_____

Phone Number (Home) _____

(Business)_____

Email Address_____

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

Address: _____

_____

Phone Number (Home) _____

(Business)_____

Email Address_____

4. 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

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

_____	_____	_____	_____
Test	Evaluator	IQ Score	Date of Evaluation

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

If Yes:

7. 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

8. List Applicant's Work Experience.

_____
Employer

_____ _____ _____
Dates Employed Date of Separation Position Held

_____
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

_____

9. 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)

10. Has applicant applied for Autism Waiver? ___ No ___ Yes
11. Has applicant applied for DDA funding? ___ No ___ Yes

12. 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)

13. 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

14. Name of Psychiatrist/Physician Prescribing Medication: _____

_____

15. 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

_____
_____
_____
_____

16. Financial. List of 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				

17. Has applicant been declared incompetent by the court? (Guardianship)/(POA)
___ Yes ___No
(If yes, attach court document/ If not, Guardianship/POA must be established)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____
_____
_____
_____

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

_____
_____

Supporting Documents (minimum requirements)

- Application for Services
- Referral letter (for students only)
- IEP (students only), IP (adults only)
- Behavior Plan
- Current psychological assessment with autism diagnosis
- Proof of the applicant's age
- Matrix score (sent with the CSS company letterhead or from the CSS email account)
- Medical history and immunization records
- Written list of current medications
- Record of recent physical examination
- Current doctor's orders
- Discharge summaries from any hospitalizations related to autism
- Names of doctors and dentists

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

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

_____
_____
_____
_____

Return completed application to:

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

Email: cbrown@csaac.org
Telephone: 240-912-2362
Facsimile: 240-813-1006