Date of Application_____

APPLICATION FOR STUDENTS TRANSITIONING TO ADULT SERVICES

Instructions: Completion of this form is the first step in applying for adult services. It is recommended that you complete and keep the original, and make copies for the providers to which you want to apply. Though additional documentation may be requested, the following service providers have agreed to accept this universal application:

- ✓ Arc Prince George's County
- ✓ Ardmore Enterprises
- ✓ CHI Centers
- ✓ Compass
- ✓ EBED
- ✓ EPIC
- ✓ Family Services Foundation
- ✓ Full Citizenship of Maryland
- ✓ Maryland Community Connection
- ✓ Maryland Neighborly Network
- ✓ MedSource Community Services
- ✓ Melwood HTC
- ✓ New Horizons Support Services
- ✓ Rehabilitation Opportunities
- ✓ SEEC
- ✓ Social Health Services Group
- ✓ Sunrise
- ✓ VOCA/ResCare

APPLICANT INFORMATION

Full Name_____

Phone#_____ Social Security#_____ Date of Birth_____

Current Address_____

Permanent Address_____

Ethnic Identification *(optional)*:

☐African American ☐Asian ☐Caucasian ☐Latino ☐Native American ☐Other:_____

Gender: ☐Male ☐Female U.S. Citizen: ☐Yes ☐No

Height___' ___" Weight____lbs Eye Color_____ Hair Color_____

Language(s) spoken or understood: ☐English ☐Other:_____

Language(s) spoken in applicant's home: ☐English ☐Other:_____

GUARDIAN/CAREGIVER INFORMATION

Name_____ Relationship to Applicant_____

Living Situation/Support: ☐Family ☐Foster Home ☐Legal Guardian of Adult*

**Type of Guardianship:* ☐*Person* ☐*Property* ☐*Medical* ☐*Limited Power of Attorney*

*Date and County of Adjudication*_____

Address_____ (☑ *preferred contact below*)

Phone #'s: ☐Home_____ ☐Cell_____ ☐Work_____

☐Email_____ Best time to reach you_____

EMERGENCY CONTACTS *(use additional paper if necessary)*

Name_____ Relationship to Applicant_____

Address_____ (☑ *preferred contact below*)

Phone #'s: ☐Home_____ ☐Cell_____ ☐Work_____

☐Email_____

Name_____ Relationship to Applicant_____

Address_____ (☑ *preferred contact below*)

Phone #'s: ☐Home_____ ☐Cell_____ ☐Work_____

☐Email_____

FAMILY INFORMATION

Parent Information	**Father**	**Mother**
Name		
Address		
Home Phone		
Cell Phone		
Business Phone		
Date of Birth		
If deceased, date of death		

Siblings/Other Family Members Living in the Household ***(use additional paper if necessary)***			
Name			
Relationship to Applicant			
Phone			
Date of Birth			

MEDICAL INFORMATION

A. Diagnoses:

Primary Disability_____

Additional Diagnosis_____

B. Medications *(use additional paper if necessary)*

Medication	Dosage & Frequency	Purpose

C. Insurance Information:

Applicant's Medicare#_____ Type_____

Other Medical Insurance (company & policy#)_____

D. Healthcare Provider Information:

Primary Care Physician_____ Phone#_____

Address_____

Preferred Hospital_____

Dentist_____ Phone#_____

Dentures or other prosthetic? ☐No ☐Yes:_____

Specialist_____ Phone#_____

Specialist_____ Phone#_____

Specialist_____ Phone#_____

E. General Health Information - *(check all that apply):*

☐Vision impairment ☐Legally Blind ☐Glasses ☐Contact Lenses

☐Hearing impairment ☐Deaf ☐Hearing Aid

☐Seizure disorder *(type)*_____ Controlled with medication: ☐Yes ☐No

☐Speech or language impairment

Means of communication: ☐Speech ☐Sign/ASL ☐Gestures ☐Picture/Symbol Device

Speech/language assessment by_____ Date_____ ☐N/A

Does the applicant have *(check all that apply and explain below):*

☐ other medical conditions not listed above?

☐ a history of significant surgeries or hospitalizations?

☐ a special diet; use adaptive dishes/utensils; or need feeding assistance?

☐ any allergies (environmental, medication, foods, etc.)?

MENTAL HEALTH/PSYCHOLOGICAL

Most recent psychological exam by _____ Date_____ ☐N/A

Does the applicant have a history of behavioral concerns? ☐Yes ☐No

Does the applicant have a current behavior plan in school? ☐Yes ☐No

If yes to either of the above, please briefly explain below *(use additional paper if necessary):*

EDUCATION

Schools and/or Adult Programs Attended ***(use additional paper if necessary)***

Name	Address	Dates Attended

SKILLS, SAFETY, AND SUPPORT NEEDS

A. Mobility *(check all that apply):*

☐ Walks Independently Uses Assistive Device(s): ☐ Canes or Crutches ☐ Walker ☐ Wheelchair

Wheelchair type_____ Transfers: ☐ Independently ☐ With assistance

Community/Pedestrian Safety:

Able to cross streets: ☐ Independently ☐ With assistance ☐ Not at this time

Uses mass transit: ☐ Independently ☐ With assistance ☐ Not at this time

Uses Paratransit/Metro Access: ☐ Independently ☐ With assistance ☐ Not at this time

Metro Access eligibility/ID card: ☐ Yes ☐ No

B. Activities of Daily Living:

Independent in personal self-care (e.g. hygiene, eating, toileting) ☐ Yes ☐ Somewhat ☐ No

If applicable, level of assistance needed: ☐ verbal prompt ☐ stand-by support ☐ fully assist

Is able to independently self-medicate: ☐ Yes ☐ No

Is capable of remaining home unsupervised: ☐ Yes ☐ No *If Yes, for_____ hours*

C. Routines:

Usually sleeps through the night: ☐ Yes ☐ No

Usually goes to bed at (time)_____ and gets up at_____

Provide a brief description of daily routine:

D. Skills and Interests:

Reads: ☐ No ☐ Yes - level:_____ Writes: ☐ No ☐ Yes - level:_____

Hobbies/Interests:_____

Other:_____

EMPLOYMENT

Is the applicant currently employed? ☐No ☐Yes - Provide employment information below:

Employer_____ Phone#_____

Address_____

Supervisor's Name_____ Phone#_____

Job Title_____ Start date_____ Wage $_____

Duties_____

Previous Employment *(use additional paper if necessary):*

Company Name	Address	Phone#
Job Title	Supervisor's Name	Dates Employed

Company Name	Address	Phone#
Job Title	Supervisor's Name	Dates Employed

Company Name	Address	Phone#
Job Title	Supervisor's Name	Dates Employed

If applicant is not currently employed, what are his/her job interests?

FINANCIAL INFORMATION *(Complete only if seeking residential services)*

SSI Claim#_____ SSI Amount $_____ SSA Claim#_____ SSA Amount $_____

Representative payee/relationship to applicant_____

Other Applicant Income_____

Bank_____ Account Types: ☐Checking ☐Savings ☐Other:_____

Trust Fund: ☐No ☐Yes - Type_____

Name and address of trustee_____

Assets in applicant's name *(location &value)*_____

ADDITIONAL TEAM MEMBERS

Does applicant have a Coordinator of Community Services (CCS)? ☐Yes ☐No

If yes, name and phone#_____

Does applicant have a DORS Counselor? ☐Yes ☐No

If yes, name and phone#_____

Does the applicant have a Social Worker? ☐Yes ☐No

If yes, name and phone#_____

Indicate current services or financial assistance and provider:

☐Respite:_____ ☐In-Home Supports:_____ ☐LISS:_____

☐Foster Care:_____ ☐REM:_____ ☐CFC:_____

☐Other:_____

SIGNATURES

_____ _____

Signature of Applicant (if over 18 year old) *Date*

_____ _____

Signature of parent/guardian (if applicable) *Date*

_____ _____

Signature of Person Completing Form *Date*

OFFICE USE ONLY

Application received_____ Category: ☐Crisis Resolution ☐Crisis Prevention ☐Current Request/TY

Authorized for:

☐Supported Employment ☐Employment Discovery & Customization ☐Community Learning Services

☐Day Habilitation ☐Self-Directed Services

☐*Residential Habilitation* ☐*Personal Support Services* ☐*Shared Living*

Comments/Notes: