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 Co
* Ardmore Enterprises
* CHI Centers
* Compass, Inc.
* EBED
* EPIC
* Family Services Foundation
* Full Citizenship of Maryland
* Maryland Community Connection
* Maryland Neighborly Network
* MedSource Community Services
* Melwood HTC
* New Horizons Support Services
* Opportunities, Inc.
* SEEC
* Social Health Services Group
* Sunrise/UCP on the Potomac
* VOCA/ResCare

**APPLICANT INFORMATION**

Full Name:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Home[ ]  Mobile

Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Current Address (if more than one please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­

**Financial:**

Current Recipient of SSI? [ ] Yes [ ] No [ ] Pending Approval

Authorized Representative? [ ] Yes [ ] No

If Yes, Name/Relationship to Applicant; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnic Identification (optional):**

[ ]  African American [ ] American Indian/Alaska Native [ ] Asian [ ] Hispanic/Latino

 [ ] Two or More Races(non-Hispanic) [ ] Other:­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender**: [ ] Male [ ] Female [ ] Transgender Male [ ] Transgender Female [ ] Nonbinary

**Preferred Pronouns**: [ ] He/Him [ ] She/He [ ] They/Them

**Height**­­­­\_\_\_\_\_\_\_\_\_\_\_\_ **Weight\_\_\_\_\_\_\_\_\_\_\_ Eye Color\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hair Color\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Language(s) Spoken and Understood:** [ ] **English** [ ] **Spanish** [ ] **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Language(s) Spoken in Applicant’s Home:** [ ] **English** [ ] **Spanish** [ ] **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GUARDIAN/CAREGIVER INFORMATION**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Living Situation/Support:** [ ] Family [ ] Group Home/Foster Home [ ] Own Home [ ] State/Local Facility

 [ ] Legal Guardian of Adult\*

*\*Type of Guardianship:* [ ] Person [ ] Property [ ] Medical [ ] Limited Power of Attorney

*Date and County of Adjudication:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ([x] preferred contact)

**Phone #’s:** [ ] Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best time to reach you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contacts:** (use additional paper if necessary)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ([x] preferred contact)

**Phone #’s:** [ ] Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ([x] preferred contact)

**Phone #’s:** [ ] Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Parent Information** | **Parent 1**  | **Parent 2** |
| **Name** |  |  |
| **Relationship** |  |  |
| **Address** |  |  |
| **Preferred Phone #** |  |  |
| **Alt. 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** |  |  |

M**EDICAL INFORMATION**

 Primary Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Additional Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage and Frequency** | **Purpose** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

 **Insurance Information:**

 Applicant’s Medicaid# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical Insurance (company and policy#)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider Information:**

**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentures or other prosthetic? [ ] No [ ] Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health Information (*check all that apply):***

[ ] Vision Impairment [ ] Legally Blind [ ] Glasses [ ] Contact Lenses [ ] Hearing Impairment [ ] Deaf [ ] Hearing Aid(s) [ ] Seizure Disorder (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Take medication? [ ] Yes [ ] No

[ ] Speech/Language Impairment

**Communication Style:** [ ] Speech [ ] Sign/ASL [ ] Gestures [ ] Assistive Technology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speech/language assessment by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] N/A

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

[ ] Other medical conditions not listed above?

 [ ] History of significant surgeries or hospitalizations?

[ ] A special diet; use adaptive dishes/utensils; or need feeding assistance?

[ ] Have 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**:

Mobility (check all that apply):

 [ ] Walks Independently [ ] Uses Cane or Crutches Walker [ ] Uses Wheelchair- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Transfers: [ ] Independently [ ] With assistance

Community/Pedestrian Safety:

Able to cross streets: [ ] Independently [ ] With assistance [ ] Only with Supervision Uses mass transit: [ ] Independently [ ] With assistance [ ] Only with Supervision

Uses Paratransit/Metro Access: [ ] Independently [ ] With assistance [ ] Only with Supervision Metro Access eligibility/ID card? [ ] Yes [ ] No

**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

Able to medicate independently? [ ] Yes [ ] No

Able to be at home unsupervised? [ ]  [ ] Yes No If Yes, for how long? \_\_\_\_\_\_\_\_\_\_

Routines:

Usually sleeps all night? [ ] Yes [ ] No

Typical Bedtime: \_\_\_\_\_\_\_\_ Wake Time: \_\_\_\_\_\_\_\_\_\_

Provide a brief description of daily routine:

**Skills and Interests:**

Able to read? [ ] Yes [ ] No [ ] With Support

Write? [ ] Yes [ ] No [ ] With Support

Hobbies/Interests:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clubs/Organizations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT**

Is the applicant currently employed? [ ] No- List job interests if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes - Provide employment information below: Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Wage: \_$\_\_\_\_\_\_\_\_\_\_\_\_

Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Employment (use additional paper if necessary):

|  |  |  |
| --- | --- | --- |
| **Employer Name** | **Title** | **Dates Employed** |
|  |  |  |
| **Address** | **Supervisor Name** | **Reason for leaving** |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Employer Name** | **Title** | **Dates Employed** |
|  |  |  |
| **Address** | **Supervisor Name** | **Reason for leaving** |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Employer Name** | **Title** | **Dates Employed** |
|  |  |  |
| **Address** | **Supervisor Name** | **Reason for leaving** |
|  |  |  |

**Services of Interest:**

[ ] Behavioral Support Services

[ ] Community Development Services (CDS)

[ ] Community Living Group Home

[ ] Employment Services

[ ] Family Support Services

[ ] Housing Support Services

[ ] Personal Supports

[ ] Respite

[ ] Supported Living

[ ] Transportation

Comments/Notes:

**ADDITIONAL TEAM MEMBERS**

Does applicant have:

[ ] Coordinator of Community Services (CCS)?

Name/Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Division of Rehabilitation Services (DORS) Counselor?

Name/Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other Support/Social Worker?

Name/Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURES**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Applicant (if over 18 years old)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Parent/Guardian (if applicable)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Person Completing this form*