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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred contact)

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

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

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

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