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