Date of Application: _______________

Application for Students Transitioning into Adult Services

This form has been developed in collaboration with the Baltimore County Public School System, the Developmental Disabilities Administration, Service Coordination, Inc., and the adult service providers serving Baltimore City and Baltimore County.

APPLICANT'S INFORMATION

Name: ____
Last First Middle

Date of Birth:______/______/______ Place of Birth: ____________________________

Current Address: ____
Street City State Zip

Permanent Address: ____
Street City State Zip

Telephone #: ______________________________Social Security #: ____________________

PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: __________________________________ Relationship to Applicant: ______________

Address: ____

Telephone #: ______________________________ Cell/Work #: ________________________

E-mail Address: ____

What is the best way and time to reach you?: ____

LIVING SITUATION (please include names)

Parents: ____________________________ Guardians or Relatives: ______________________

Foster Home: _______________________ Other: _____________________________________

Address: ____

Phone #: ____________________________ Legal Guardian: _____________________________

Date Guardianship was attained: ________ Number of occupants living in the home: ________

Type of Guardianship (check which applies):

☐ Full ☐ Property ☐ Limited ☐ Medical ☐ Person

FAMILY INFORMATION

Parent Information:

	Father	Mother
Address		
Home Phone		
Cell Phone		
Business Phone		
Occupation		
Date of Birth		
Deceased (yes/no)		
Date of Death		

Sibling Information (use additional paper if necessary):

Siblings Name			
Address			
Phone			
Occupation			
Date of Birth			

Other Family Members Living in the Household (use additional paper if necessary):

Name			
Address			
Phone			
Occupation			
Relationship			
Date of Birth			

FINANCIAL INFORMATION

SSI Claim #: ______________________________ SSI Amount: _________________________

SSA Claim #: _____________________________ SSA Amount: _________________________

Name of representative payee/relationship to applicant: ___________________________________

Other sources of Applicants Income: ____

Account Types: ☐ CHECKING ☐ SAVINGS Bank Name: ____________________

Property in applicant's name (list location and value): ____________________________________

Trust Fund: ☐ YES ☐ NO Type: ____

If yes, give name and address of trustee: ____

____

MEDICAL INFORMATION

A. Diagnoses:

Primary Diagnosis: ____

Additional Diagnosis: ____

Additional Diagnosis: ____

B. Medications (use additional paper if necessary):

Medication	Dosage	Frequency	Reason

C. Insurance Information:

Applicants Medicaid/Medical Assistance #: ____________________________________

Dates Covered under Medicaid/Medical Assistance: _____________________________

Applicants Medicare #: _____________________ Type: ________________________

Other Medical Insurance (list company name and policy #): _______________________

____

D. Physician and Dentist Information:

Applicant's Primary Physician: ____

Address: ____

Phone #: _________________________ Date of Last Exam: ___________________

Examined By: _____________________ Hospital familiar with Applicant: ________

Applicant's Dentist: ____

Address: ____

Phone #: _________________________ Date of Last Exam: ___________________

Does the applicant wear dentures? ☐ YES ☐ NO

Briefly list any dental problem(s): ____

E. Vision and Hearing:

Does the applicant have a vision impairment? ☐ YES ☐ NO

Is the applicant legally blind? ☐ YES ☐ NO

Does the applicant wear: ☐ Glasses ☐ Reading Glasses ☐ Contact Lenses

Date of last eye exam: ___________ Place where exam took place: ________________

Does the applicant have a hearing impairment? ☐ YES ☐ NO

Does the applicant wear a hearing aid? ☐ YES ☐ NO

Is the applicant deaf? ☐ YES ☐ NO

Date of last hearing exam: ___________ Place where exam took place: _____________

F. Speech and Language:

Does the applicant have a speech or language impairment? ☐ YES ☐ NO

Is the applicant verbal? ☐ YES ☐ NO

Has the applicant had a speech/language assessment? ☐ YES ☐ NO

Assessment completed by: ______________________ Date of Assessment: ________

Applicant means of communication:

☐ Speech ☐ Sign Language ☐ Gestures ☐ Communication Board

G. Seizures:

Does the applicant have seizures? ☐ YES ☐ NO Frequency: _____________

Type: ______________ Are seizures controlled by medication? ☐ YES ☐ NO

H. Mobility:

☐ Walks Independently ☐ Uses Canes ☐ Uses Crutches ☐ Uses Walker

☐ Uses Wheelchair Type: _________________________

Can the wheelchair user: ☐ Transfer Independently ☐ Needs Assistance

I. Other:

Does the applicant have any other medical conditions not listed above?

____

Has the applicant had any significant surgeries or hospitalizations?

____

Does the applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

____

Does the applicant have any allergies (environmental, medication, foods, etc.)?

____

Does the applicant:
☐ Use the bathroom independently
☐ Need transfer assistance to the toilet
☐ Wear diapers

MENTAL HEALTH / PSYCHOLOGICAL

Applicant's Psychiatrist: ____

Address: ____

Phone #: ____________________________ Date of Last Visit: ___________________

Applicant's Psychologist: ____

Address: ____

Phone #: ____________________________ Date of Last Visit: ___________________

Applicant's Therapist: ____

Address: ____

Phone #: ____________________________ Date of Last Visit: ___________________

Date of last psychological evaluation: __________ Performed by: ______________________

Does the applicant have a history of behavioral problems? ☐ YES ☐ NO

If yes, list below (use additional paper if necessary):

Behavior	Frequency	Severity	Intervention

EDUCATION

Schools or Adult Programs Attended (use additional paper if necessary):

Program	Address	Dates Attended

Vocational Programs or Trainings Attended (use additional paper if necessary):

Program	Address	Dates Attended

SKILLS

1. Is the applicant independent in personal self-care skills? ☐ YES ☐ NO
   (e.g. bathing, dressing, feeding, toileting)

2. Can the applicant self-medicate? ☐ YES ☐ NO

3. Can the applicant cross streets? ☐ Independently ☐ With Assistance ☐ No

4. Can the applicant use mass transit? ☐ Independently ☐ With Assistance ☐ No

5. Is the applicant capable of remaining home unsupervised? ☐ YES ☐ NO

   If yes, for how long: ____

6. Can the applicant read? ☐ YES ☐ NO If yes, what level: ________________

7. Can the applicant write? ☐ YES ☐ NO If yes, what level: ________________

8. Does the applicant sleep through the night? ☐ YES ☐ NO

9. What time does the applicant usually go to bed? _______ Get up in the morning? ______

10. What does the applicant like to do with his/her free time? _________________________

    ____

11. Please provide a brief description of the applicants daily routine: ___________________

    ____

    ____

12. Has the applicant received or is the applicant currently receiving any types of services or financial assistance (i.e. Rolling Access funds, respite Services, In-Home Support Services, Foster Care, etc.)? If yes, please list below:

    ____

EMPLOYMENT

Is the applicant currently employed? ☐ YES ☐ NO

If yes, what is the employment address: ____

Phone #: ________________________________ Supervisor's Name: ____________________

Job Title: ____________________ Start date: _____________ Wage: __________________

Duties: ____

Previous Employment (use additional paper if necessary):

____

Company Name Company Address Company Phone #

____

Job Title Supervisor's Name Dates Employed

____

Company Name Company Address Company Phone #

____

Job Title Supervisor's Name Dates Employed

____

Company Name Company Address Company Phone #

____

Job Title Supervisor's Name Dates Employed

If the applicant is not currently employed, what are their job interests? _____________________

____

SIGNATURES

____ ________________________

Signature of Applicant (if over 18 year old) Date

____ ________________________

Signature of parent/guardian (if applicable) Date

____ ________________________

Signature of Person Completing the Form Date

****

FOR OFFICE USE ONLY

Date application was received: ________________________________

Critical needs list: ☐ YES ☐ NO

Level of services approved:

☐ Day Habilitation

☐ Residential

☐ In-Home Support Services

☐ Vocational

☐ Medical Day Habilitation

Comments/Notes: ____

____

____

The agencies who have collaborated on this form provide services and operate their facilities without discrimination on the basis of race, color, national origin, religion, political affiliation, sexual orientation, marital status, age, sex, or disability. The following information is useful for statistical purposes only and completion of this portion of the application is voluntary.

Ethnic Identification (check if applicable):

☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American

☐ Asian ☐ Other: ____

Language(s) spoken or understood: ☐ English ☐ Other, specify: _______________

Language(s) spoken in applicant's home: ☐ English ☐ Other, specify: _____________

U.S. Citizen? ☐ YES ☐ NO

Sex: ☐ MALE ☐ FEMALE

Height: __________ Weight: __________ Eye Color: __________ Hair Color: __________