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:

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<th>Father</th>
<th>Mother</th>
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<td>Home Phone</td>
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<td>Cell Phone</td>
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<td>Business Phone</td>
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<td>Occupation</td>
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<td>Date of Birth</td>
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<tr>
<td>Deceased (yes/no)</td>
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<td>Date of Death</td>
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#### Sibling Information (use additional paper if necessary):

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<th>Siblings Name</th>
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#### Other Family Members Living in the Household (use additional paper if necessary):

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<td>Relationship</td>
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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):

<table>
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<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason</th>
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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):

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Frequency</th>
<th>Severity</th>
<th>Intervention</th>
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EDUCATION

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

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<th>Program</th>
<th>Address</th>
<th>Dates Attended</th>
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Vocational Programs or Trainings Attended (use additional paper if necessary):

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<th>Program</th>
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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):

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Company Address</th>
<th>Company Phone #</th>
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<tbody>
<tr>
<td>Job Title</td>
<td>Supervisor’s Name</td>
<td>Dates Employed</td>
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If the applicant is not currently employed, what are their job interests? ________________

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

________________________________________
Signature of parent/guardian (if applicable)     Date

________________________________________
Signature of Person Completing the Form     Date
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: __________