

*For Internal Use Only*

Date Received:	DDS CS #:	DDS CS Status:
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Documentation of Autism Diagnosis:  Yes  No

**ADL Issues Noted:**

Communication  Mobility  Contenance  Eating  Behavior/Attitude  Sleep  Bathing/Dressing  Health Status

**Recommendation of Service Coordinator:**  Approve  Deny Comments \_\_\_\_\_  
Amount Requested: \_\_\_\_\_ Signature & date \_\_\_\_\_

**Recommendation of Title V Regional Manager:**  Approve  Deny Signature & date \_\_\_\_\_  
Dollar amount approved \_\_\_\_\_

## Special Needs Autism Program Application

**Applicant (Individual with Autism) Information**

Last Name	First Name	Middle Initial	
/			
Date of Birth	Age	Social Security #	Medicaid #
Parent/Guardian Name		Contact Phone: (____) _____	( <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work)
Street Address	City	Zip Code	County
Mailing Address	City	Zip Code	

**I. Diagnosis:** \_\_\_\_\_

**Diagnosis in addition to Autism:** \_\_\_\_\_

**II. Applicant's Strengths & Needs – (Mark all that apply. Feel free to elaborate on additional paper)**

**A. Communication – Speech/Language**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Age appropriate communication         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the applicant talk?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the applicant understand others? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do others understand the applicant?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**B. Mobility**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Assistance needed                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Individual will wander off or run away if unsupervised | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**C. Contenance (toilet trained)**

- |                              |                              |                             |  |
|------------------------------|------------------------------|-----------------------------|--|
| 1. Age appropriate toileting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| 2. Uses diapers              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Night-time only |

