The Autism Friendly Village

[Centre for Alternative Residential Environment for Children & Adult with Autism]

Kesavaram Village, Shameerpet Mandal, RR Dist. 500078

Application for Residency

Date of Application …/…./2013

Name of Applicant_______________________________ Date of Birth___________________ Gender :M / F

Name of Father /Guardian_________________________ Mother's Name: _________________________________

If Single Parent : Yes / No Divorcee / Widow / Widower …………………………….

Address____ Phone (primary)_____________________

Other phone: work / Mobile ______________________________ Email_________________________@_________

Diagnosis:

Primary diagnosis of Applicant ________________________ Other diagnoses______________________________

Date of diagnosis of autism/ASD__________________ Age of applicant when diagnosed with autism/ASD____YO

Present Needs: Please check all that apply, and circle your most urgent need

	Yes	Somewhat	No
Adult residence	☐	☐	☐
Clinical consultation	☐	☐	☐
Recreation/leisure	☐	☐	☐
Vocational/work	☐	☐	☐
Other (specify):	☐	☐	☐

Funding and Supports Profile:

Natural supports:	**(0) No/NA**	**(1) Somewhat**	**(2) Yes**
My parents are very involved in my life	☐	☐	☐
My siblings are very involved in my life	☐	☐	☐
My Grandparents family is very involved in my life	☐	☐	☐
My_______________is very involved in my life	☐	☐	☐
I get help and support from________________	☐	☐	☐
I have personal financial resources	☐	☐	☐

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Functional Capabilities: **This checklist will help to determine how best to support the resident and is not a pass/fail assessment. (0) NA-not applicable (1) FI-Fully independent (2) PI- Partially Independent (3) FS-Full support needed**

	0 N/A	1 FI	2 PI	3 FS
Toileting	☐	☐	☐	☐
Bathing: shower/bath (circle)	☐	☐	☐	☐
Brushing teeth	☐	☐	☐	☐
Physical mobility	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Meal preparation	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Use of public transportation	☐	☐	☐	☐
Assistive devices	☐	☐	☐	☐
Taking medication	☐	☐	☐	☐
Ability to use phone	☐	☐	☐	☐
Housekeeping/laundry	☐	☐	☐	☐
Money management	☐	☐	☐	☐
Ability to respond in emergency	☐	☐	☐	☐
Functional verbal communication	☐	☐	☐	☐
Non-verbal functional communication	☐	☐	☐	☐
Crossing the street	☐	☐	☐	☐
Staffing need: Day	☐	☐	☐	☐
Staffing need: Night	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Following one-step direction	☐	☐	☐	☐
Following multi-step direction	☐	☐	☐	☐
Telling time	☐	☐	☐	☐

Please comment on any areas that need additional explanation:

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Psychosocial Profile: This checklist will help to determine how best to support the resident and is not a pass/fail assessment. (1) Mi-minimal factor/concern (2) Mo-Moderate factor/concern (3) S-Significant factor/concern

	1 Mi	**2 Mo**	**3 S**
Anxiety	☐	☐	☐
Agitation	☐	☐	☐
Aggression toward:			
Property	☐	☐	☐
Other people	☐	☐	☐
Self	☐	☐	☐
Animals	☐	☐	☐
Depression	☐	☐	☐
Rigidity	☐	☐	☐
Difficulty with transition	☐	☐	☐
Sensory Processing challenges:			
Visual	☐	☐	☐
Spatial	☐	☐	☐
Auditory	☐	☐	☐
Tactile	☐	☐	☐
Dietary	☐	☐	☐
Other_________________	☐	☐	☐
Self-perception	☐	☐	☐
Sustaining peer relationships	☐	☐	☐
Recognition of personal space/property	☐	☐	☐
Social/emotional reciprocity	☐	☐	☐
Elopement	☐	☐	☐
Distractibility	☐	☐	☐
Focus/On-task ability	☐	☐	☐
Impulsivity	☐	☐	☐
Oppositional behavior	☐	☐	☐
Self-stimulatory behavior	☐	☐	☐
Self-regulation of food intake	☐	☐	☐

Total Score:________

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Please comment on any areas that need additional explanation:

Residential History:

Have you lived outside your parent's home? _____Yes _____No

If so, where?

May we contact the agency of the residence where you lived outside of your parent's home for verification purposes? If yes, please sign below:

_______________________________________ parent ☐ guardian ☐ Date_____________________

Have you lived independently or in Supported Independent Living (SIL)? (underline) ____Yes ____No

If so, where and for how long?

What worked well for you with independent or SIL?

What were challenges for you with independent or SIL?

Have you lived in a group home? ___Yes ___No

If so, which one(s) and for how long?

What worked for you in the group home?

What were challenges for you in the group home?

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Biography: **Please let us know, by separate attachment, about you and your family, your goals and your challenges. Caregivers and family members are encouraged to participate. Some helpful information would be:**

- What are your strengths?
- What are your challenges?
- What are your hopes and dreams for life…what would a fulfilling life look like for you?
- What comforts you? What upsets you?
- How do you describe yourself?
- Who is in your family? Who is most important to you in your family? What is it like?

History:

Please attach relevant testing, reports, or evaluations to include IEPs and psychiatric or psychological testing

Diagnostic/Cognitive Function

Medical

Social Communication

Educational

Vocational

Current Natural Supports (i.e. family, close friends, others who care about you)

Any other information : ………………………………………………………………..

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Functional Assessment:

Please attach relevant testing, reports, or evaluations to include IEPs and psychiatric or psychological testing

Current medications: -

Name	Dose	Purpose	Name of prescribing physician	Contra-indications

Hospitalization/Surgeries

Special dietary needs

Specialized equipment or therapy

Communication method(s) and augmentative supports

Environmental needs

Sensory needs

Staffing requirement: Day and Night

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Declaration :

1. I understand that I have to visit my parents / family every year from May 15th – June 10th & Dec 15th – Jan 10th .

2. I agree to obey all the rules and regulation.

3. I agree to pay all operational costs in advance.

Mother's Name : ______________________________

SIGNATURE : ______________________________

Father / Guardian's Name: ______________________________

SIGNATURE : ______________________________

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