**Autism Services Association, Inc.**

**47 Walnut Street, Wellesley Hills, MA 02481**

**TEL: (781) 237-0272 Fax: (781) 237-5020**

**E-Mail: sheelaasa@autismservicesassociation.org**

**Website:** [**www.autismservicesassociation.org**](http://www.autismservicesassociation.org/)

PROGRAM APPLICATION

**DATE OF APPLICATION**

**I. Applicant’s Name**

Date of Birth

Address

Social Security #

Phone #

Applicant’s Mass. Health # (If applicable)

**II. Parent(S) Name**

(H) Phone #

Address

(W) Phone #

**III. Guardian’s Name** \_ (H) Phone

Address

(W) Phone #

IV. **DMR Service Coordinator/ Rehab Councilor or School District Representative:**

Name

Phone #

Address

V. Applicant’s Current Program

Contact Person

VI. Functional Limitations

**VII. Attach a copy of applicant’s current Individual Support Plan (ISP) or Individual**

**Education Plan (IEP).**

**VIII. Attach a copy of applicant’s most recent medical, psychological, educational,**

**vocational, and speech/language evaluations.**

**Return completed Application to: Program Director, Autism Services Association Inc.,**

**47 Walnut St.**

**Wellesley Hills, Ma. 02481**

**Autism Services Association**

**Referral Check list**

Participant:

Project Director:

Date:

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **DATE OF TOUR** |  |  |
| **PROGRAM APPLICATION** |  |  |
| **INTAKE INTERVIEW** |  |  |
| **ACCEPTANCE LETTER** |  |  |
| **CONSUMER HANDBOOK** |  |  |
| **SEVERITY PROFILE (if indicated)** |  |  |
| **CURRENT ISP/ IEP/ITP/** |  |  |
| **Interim Day Hab. Service plan**  **(after 5 days if indicated)** |  |  |
| **SOCIAL HISTORY** |  |  |
| **MEDICAL HISTORY** |  |  |
| **PHYSIANS AUTHORIZATION (if**  **indicated)** |  |  |
| **PHYSICAL FORM** &  **ASA HEALTH FORM** |  |  |
| **COPY OF MEDICAL INSURANCE CARD** |  |  |
| **IMMUNIZATION RECORD** |  |  |
| **ASA’S AUTHORIZATION FORMS**  ***(MEDIA/EMPLOYMENT RELEASE)*** |  |  |
| ASA’S AUTHORIZATION FOR  MONEY MANAGEMENT ***(COMMUNITY FUNDS, BANK ACCOUNT/ CASH CHECKS)*** |  |  |
| **BIRTH CERTIFICATE** |  |  |
| **PICTURE IDENTIFICATION** |  |  |
| **COPY OF SOCIAL SECURITY**  **CARD** |  |  |
| **GUARDAINSHIP DECREE** |  |  |
| **GUARDIAN/PARENT/PARTICPANT AUTHORIZATION** |  |  |



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**HEALTH HISTORY (YES, NO, GIVE DATES IF APPICABLE)**

**NAME: DATE:**

CURRENT

MEDICATIONS

SIDE EFFECTS TO

MEDICATION

HEART DEFECT/DISEASE: YES NO DIABETES: YES NO

SEIZURES: YES NO

BLEEDING/ CLOTTING DISORDERS: YES NO ALLERGIES (please state: medications, pollen, mold,

etc.)

ASTHMA YES NO

OPERATIONS OR SERIOUS INJURIES

(DATED)

CHRONIC OR RECURRING ILLNESS(Please

state)

ANY RESTRICTED ACTIVITIES: YES NO IF YES, PLEASE STATE:

PHYSICALLY FIT TO WORK: YES NO

OTHER PERTINENT INFORMATION:

HAS THE INDIVIDUAL HAD ALL IMMUNIZATIONS TB(DATE)

INCLUDING

DATE OF LAST PHYSICAL

Doctor

Doctors Address & phone number include hospital

Height

Weight\_

SPECIAL

DIET

NUTRITION(CIRCLE) GOOD POOR OBESE UNDERWEIGHT

**IF TWO PLEASE GIVE BOTH OF MEDICAL INS./MEDICAID &**

**#**

**Insurance Carrier**

**PLEASE INCLUDE THE FOLLOWING INFORMATION CURRENT PHYSICAL & SIDE EFFECTS TO MEDICATION**

**DENTIST\_**

**DATE OF LAST EXAM**

*Information, Referral, Education, Supported Employment and Rehabilitation Services*

*Serving Central and Eastern Massachusetts*

**AUTHORIZATIONS**

PARTICIPANT

NAME

1. This is to authorize ASA to act in sharing the responsibility of the delegation of small amounts of client funds for use in various community experiences and activities.

2. I give ASA permission, as needed, to open a bank account for the above program participant and to deposit and withdraw funds.

3. I give permission, as needed, to cash all pay checks for the above program participant and to keep those monies at ASA to be used for community funds.

4. I understand that if the program participant is placed in a competitive employment job where he or she is paid directly by the employer, that I will participate in the payment of IRWE (IMPAIRMENT RELATED WORK EXPENSES), a program through the Social Security Administration.

5. I understand that to ensure safety, if there are behavioral issues that may cause self-injury, injury to others or property destruction, that restraint and containment may be used or that 911 may be called.

Signature (Guardian, if indicated)/ Date



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**RELEASE OF MEDIA INFORMATION**

**I hereby give my permission to Autism Services Association, Inc., to release personal information to the media including newspapers, TV, radio, etc.**

**I give consent to the following specific media event(s) with the following restrictions (if any)**

ASA’s FACEBOOK, WEBSITE PAGE AND BROCHURE

**I hereby give consent voluntarily, without threat of punishment of prompts of special reward. I have been given the opportunity to fully discuss the release of media information and to have my questions answered. I understand that I may withdraw consent at any time prior to release without fear of punishment or reprisal.**

**Signature/ Date**

**I have fully explained the release of information from above and answered all questions to the best of my ability. It is my opinion that consent has been given knowingly and freely.**

**(Person obtaining consent) Date**

**Title, Autism Services Association, Inc.**

**Expiration Date – (not to be more than one year)**

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**EMERGENCY MEDICAL TREATMENT PERMISSION FORM**

**In the event of a medical emergency, I hereby authorize emergency medical treatment for: (Name)**

**Parent/Guardian/Date**

**Date of Birth:**

**Name of Health Plan:\_**

**Health Plan ID#:**

**Any pertinent medical**

**information:**

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**RELEASE OF EMPLOYMENT INFORMATION**

**I hereby give my permission to Autism Services Association, Inc. to release pertinent employment information for the sole purposes of obtaining employment. This material will be used in searching for job opportunities and will be given only to those persons responsible for hiring. I give consent, on the condition that the material released be used only for the above reason with the following restrictions, if any:**

**I hereby give consent voluntarily, without threat of punishment or prompts of special reward. I have been given the opportunity to fully discuss the release and to have my questions, if any, answered. I understand that I may withdraw consent at any time prior to release without fear of punishment or reprisal.**

**Signature / Date**

**I have fully explained the release of information form above and answered all questions to the best of my ability. It is my opinion that consent has been given knowingly and freely.**

**(person obtaining consent) Date**

**(Title) Autism Services Association, Inc**

**Expiration Date – Not to be more than one year**

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**AUTHORIZATION TO ATTEND AUTISM SERVICES ASSOCIATON’S DAY HABILITATION PROGRAM, PARTICIPATE IN THEIR DAY HABILITATION SERVICE PLAN AND RECEIVE ALLIED HEALTH THERAPY EVALUATIONS.**

I approve that

attend ASA’s Day Habilitation

Program and participate in his/her individual Day Habilitation Service Plan, including: Self-help, Sensorimotor, Communication, Social, Independent Living, Affective and Behavioral Development areas, including the allied health evaluations of: physical therapy, occupational therapy, speech therapy, and behavioral therapy.

Physician’s Signature Date

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**To ASA**

**Date:**

**I approve that my son/daughter attend ASA Day Habilitation Program**

**Participant:**

**Participant/Parent/Guardian Signature:**