Society for Autism Support and Services
404 – 94th Ave SE
Calgary, AB T2J 0E8 Phone: 253-2291

OUT-OF-HOME LIVING PROGRAM

Applicant's Name:_____ Attach one

Alberta Health Care No.:_____ Photograph of Applicant here

Date of Birth:_____

Gender: Male:☐ Non-Binary: ☐ or Female: ☐ Height:_____ Weight:_____

Where is applicant presently residing, if different from person completing this application:

Address:_____

PARENT 1/Guardian

Name: _____

D.O.B.: _____

Address:_____

Occptn/Title _____

Company: _____

Phone: Home: _____

Work: _____

Cell: _____

Email: _____

PARENT 2/Guardian

Name: _____

D.O.B.: _____

Address:_____

Occptn/Title _____

Company: _____

Phone: Home: _____

Work: _____

Cell: _____

Email: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Common Law ☐

Are there any Guardianship or Custody orders in place: Yes ☐ No ☐ N/A ☐

What person, if parent(s) unavailable, could be contacted in an emergency?

Name:_____ Phone:(home)_____

Address:_____ Phone:(work)_____

Relationship to Applicant:_____ Phone: (cell)_____

Languages spoken within the family home:_____

LIST BROTHERS AND SISTERS OF THE APPLICANT

NAME	GENDER	D.O.B.	LIVING AT HOME
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

OTHER PEOPLE LIVING IN THE SAME HOUSEHOLD AS APPLICANT:

NAME	GENDER	D.O.B.	RELATIONSHIP TO APPLICANT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEVELOPMENTAL HISTORY

Duration of Pregnancy: Full Term? ___ Premature? _____ Birth Weight:_____

Nature of Delivery: Natural? ☐ Caesarian? ☐ Breech? ☐ Forceps? ☐

Condition of applicant at birth: _____

_____

Health following birth:_____

If applicant was adopted: Date of legal adoption: _____

Age when placed in home? _____

At what age did applicant sit without support? _____ Crawl? _____ Stand? _____ Walk? _____

At what age did applicant say first understandable word or words?

_____

At what age did applicant say first understandable phrases or sentences?

_____

At what age did applicant begin showing attempts to dress and undress self?

_____

Is applicant right or left hand dominant? _____

If there is a history of convulsive, seizure, or epileptic disorder, please answer the following questions:

At what age did the applicant experience the first seizure? _____

How severe? (Describe): _____

Describe current seizures/disorder: _____

How often? _____

Under any particular circumstances?_____

_____

Approximate date of last seizure _____

NB: Please list any ongoing medication on the Medical History below.

Please list any behaviours that are of concern (and estimated frequency, i.e., times per day/week):

_____

_____

_____

_____

How are each of these behaviours managed?

_____

_____

_____

_____

Please describe your long-range goals and expectations for the applicant:

MEDICAL HISTORY

List any childhood diseases, operations, significant illnesses, or other pertinent information (i.e., medicine applicant is currently taking) pertaining to the applicant's medical history, including all hospitalizations:

List any allergies the applicant has:

Applicant's **Family Physician**: NAME:_____

ADDRESS:_____ PHONE: _____

When was the last time the applicant had a complete physical examination?: _____

Applicant's **Dentist:** NAME:_____

ADDRESS:_____ PHONE: _____

When was the applicant's last complete dental examination? _____

Applicant's **Optometrist:** NAME: _____

ADDRESS:_____ PHONE: _____

When was the applicant's last complete eye examination? _____

Does the applicant wear glasses or were they prescribed? Yes ☐ No ■

Has the applicant's hearing been tested:

_____

When/who completed the testing (please provide report, if available)?

_____

Please attach a copy of the applicant's immunization history.

Please comment on the types of food that the applicant eats.

_____

_____

_____

_____

Does the applicant have a restricted diet? ☐ YES ☐ NO

If yes, describe how the applicant's diet is restricted and why it is restricted:

_____

_____

_____

PROFESSIONAL CONTACT HISTORY

Please list all doctors and other health care professionals (not previously listed) who are **currently involved** or have been **previously involved** in the diagnosis and/or treatment of this applicant, and the title/specialty of each:

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

NAME:_____TITLE:_____CURRENT_____PREVIOUS_____

EDUCATIONAL HISTORY

SCHOOL	LOCATION	DATES FROM	DATES TO	COMMENTS

Current Teacher: _____

How would you describe the applicant's performance in school?

_____

_____

_____

_____

Please add here any additional remarks that would contribute to a fuller understanding of the applicant:

_____

_____

_____

_____

_____

NAME OF PERSON COMPLETING
THIS APPLICATION: _____

SIGNATURE OF PERSON COMPLETING THIS APPLICATION:_____

RELATIONSHIP TO APPLICANT (IF NOT ALREADY SPECIFIED)_____

ADDRESS AND PHONE NUMBER, IF NOT ALREADY LISTED ON THIS APPLICATION:

_____

DATE FORM COMPLETED: _____