centre FOR autism services ALBERTA

SPECIALIZED SERVICES APPLICATION

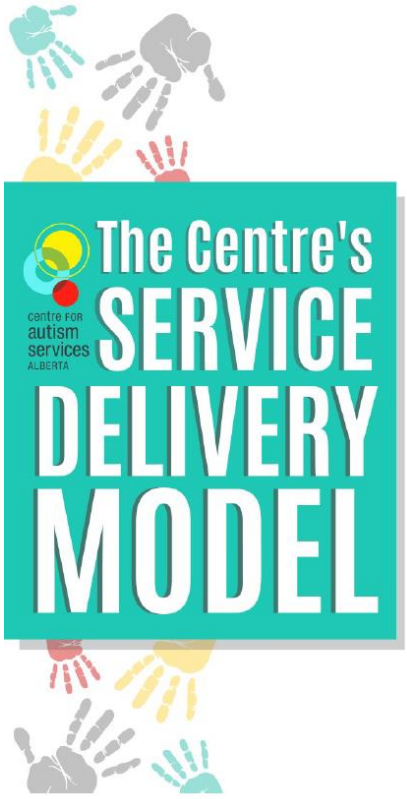
Office Use Only
Start Date: _____
Team: _____
Initials: _____

Date of Application (mm/dd/yyyy) _____

Every child is unique. Every family is unique. This means every Specialized Services program is unique and will be created according to your child's and family needs. The Centre's Specialized Services are designed to meet the unique needs of children and families severely affected by Autism Spectrum Disorders (ASD) and associated challenges. Services are provided by a multi-disciplinary team using a consultative approach and are guided by the FSCD regulation and evidence-based practices for individuals diagnosed with ASD.

With 20+ years of experience, the Centre has developed a philosophy and approach that is holistic, inclusive, values children and families, and prioritizes strategies that have been shown to work with others in similar situations.

Individualized services are delivered in the home and the community and may include psychology and behavioural consultation, speech-language and communication services, occupational therapy, physiotherapy, aide supports, family coaching, and case management.



CHILD'S INFORMATION

CHILD'S LAST NAME	CHILD'S FIRST NAME

GENDER (please circle one) Male ○ Female ○ Non-binary ○	BIRTH CERTIFICATE #	DATE OF BIRTH (mm/dd/yyyy)

ADDRESS	CITY	PROVINCE	POSTAL CODE

Has your child gone through Preschool Assessment Services (PAS) at the Glenrose?(√) Yes☐ No☐	IF YES, DATE OF ASSESSMENT (mm/dd/yyyy)

IF NO, PLACE YOUR CHILD WAS ASSESSED	DATE OF ASSESSMENT (mm/dd/yyyy)

FAMILY SUPPORT FOR CHILDREN WITH DISABILITIES (FSCD) INFORMATION

Have you been approved for Specialized Services (SS)? Yes ☐ No ☐	IF YES, WHEN (mm/dd/yyyy)

If No, where in the process are you?

☐ Information sent to FSCD, waiting for response ☐ Information not sent to FSCD ☐ Other_____

Have you ever received Specialised Services (SS) in the past?

YES☐ NO☐ If YES: Start Date_____ End date:_____

Have you ever received FSCD funded Behavioral / Developmental Supports (BDS) in the past?

YES☐ NO☐ Don't Know☐ If YES: Start Date_____ End date:_____

FSCD NUMBER	CASE WORKER'S NAME

PARENT(S) / GUARDIAN(S) INFORMATION

1) PARENT/GUARDIAN NAME (First name, Last name)			2) PARENT/GUARDIAN NAME (First name, Last name)		
HOME PHONE #	CELL PHONE #	WORK PHONE #	HOME PHONE #	CELL PHONE #	WORK PHONE #
EMAIL ADDRESS			EMAIL ADDRESS		
OCCUPATION	PLACE OF EMPLOYMENT		OCCUPATION	PLACE OF EMPLOYMENT	
CURRENTLY WORKING? (√) YES☐ NO☐ If Yes: Full Time☐ Part Time☐ Shift work☐			CURRENTLY WORKING? (√) YES☐ NO☐ If Yes: Full Time☐ Part Time☐ Shift work☐		

AVAILABILITY FOR STAFF VISITS:
(check all the apply- √)

	MORNING	AFTERNOON	EVENING
MONDAY	☐	☐	☐
TUESDAY	☐	☐	☐
WEDNESDAY	☐	☐	☐
THURSDAY	☐	☐	☐
FRIDAY	☐	☐	☐
SATURDAY	☐	☐	☐
SUNDAY	☐	☐	☐

AVAILABILITY FOR STAFF VISITS:
(check all the apply- √)

	MORNING	AFTERNOON	EVENING
MONDAY	☐	☐	☐
TUESDAY	☐	☐	☐
WEDNESDAY	☐	☐	☐
THURSDAY	☐	☐	☐
FRIDAY	☐	☐	☐
SATURDAY	☐	☐	☐
SUNDAY	☐	☐	☐

LANGUAGE FLUENCY AND CULTURAL IDENTIFICATION IS USED TO HELP WITH STAFF PLACEMENT & SUPPORT NEEDS

PRIMARY LANGUAGE SPOKEN	PRIMARY LANGUAGE SPOKEN
OTHER LANGUAGES SPOKEN	OTHER LANGUAGES SPOKEN

IF ENGLISH AS SECOND LANGUAGE: (circle one) 1 – Little to none ◯ 2 – Basic skills ◯ 3 – Speak fluently ◯ Read English? (√) Y____ N____ Write in English? Y____ N____		IF ENGLISH AS SECOND LANGUAGE: (circle one) 1 – Little to none ◯ 2 – Basic skills ◯ 3 – Speak fluently ◯ Read English? (√) Y____ N____ Write in English? Y____ N____	
IDENTIFIED CULTURE	LENGTH OF TIME IN CANADA	IDENTIFIED CULTURE	LENGTH OF TIME IN CANADA

FAMILY INFORMATION

Who has legal decision making authority for the child?

Who has legal custody of the child?

Custody arrangements, if applicable. *Please explain and attach documents*

Name of person(s) the child may **NOT** be released to:

PEOPLE WHO RESIDE IN CHILD'S HOME (check all that apply)

CHECK ALL THAT APPLY	√	*LIST NAMES AND AGES AS APPROPRIATE*
Parent 1	☐	
Parent 2	☐	
Siblings	☐	
Grandparents	☐	
Aunt/Uncle	☐	
Others	☐	

EARLY CHILDHOOD SERVICES (ECS) INFORMATION

Has your child ever received Early Childhood Supports - Program Unit Funding (PUF)? ☐ Yes ☐ No	FOR HOW MANY YEARS?	YEAR OF CURRENT OR PREVIOUS PUF:

NAME OF PRESCHOOL(S) OR KINDERGARTEN(S)

Is your child <u>currently</u> in PUF? ☐ Yes ☐ No	NAME OF PRESCHOOL/KINDERGARTEN
Will your child be PUF eligible this coming Sept? ☐ Yes ☐ No	NAME OF PRESCHOOL/KINDERGARTEN (if known)

As an approved provider for PUF (Alberta Education) and Specialized Services (FSCD) the Centre can offer a coordinated program with one team, one plan, and one approach across settings (called the Common Approach). **The Centre now offers an on-site preschool with limited spots.**
If your child qualifies, would you like more information on this option? ☐ Yes ☐ No

SCHOOL INFORMATION (if applicable)

NAME OF SCHOOL	PHONE NUMBER
GRADE	TEACHER NAME

PROGRAM (Regular class, Interactions, Other, etc)

OTHER AGENCIES

AGENCIES OR PROGRAMS YOUR CHILD IS **CURRENTLY** INVOLVED IN	DAYCARE or OUT OF SCHOOL CARE		
	Name:	Start Date:	End Date:

	Other agency/program names:		
	Name:	Start date:	End date:
	Name:	Start date:	End date:
AGENCIES OR PROGRAMS YOUR CHILD HAS **PREVIOUSLY BEEN** INVOLVED IN	Agency/Program		
	Name:	Start date:	End date:
	Name:	Start date:	End date:

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

LAST NAME, FIRST NAME	HOME PHONE #	CELL PHONE #	RELATIONSHIP TO CHILD

CHILD'S HEALTH INFORMATION

ALBERTA HEALTH CARE NUMBER	PHYSICIAN'S NAME	PHONE #

ALLERGIES (any known allergies including food)	MEDICATIONS

RELEVANT HEALTH INFORMATION	Provide any information that is useful to medical professional in case of emergency:
OTHER MEDICAL/EMERGENCY REQUESTS	Please list any additional diagnoses, hospitalizations or referrals and include DATES:

BARRIERS TO SERVICE

Do you perceive any barriers/challenges to accessing services?

CHECK ALL THAT APPLY	√	*DESCRIBE FURTHER AS APPROPRIATE*
Language/communication	☐	
Limited time	☐	
Identify as low income	☐	
Understanding the system	☐	
Driving/Transportation	☐	
Competing demands (work, family, other)	☐	
Other	☐	

How long did you wait to receive a diagnosis of ASD? (if applicable)_____

By signing below, you are providing consent for the Centre for Autism Services Alberta to contact FSCD to confirm qualification for specialized services (SS) funding. This will be required as part of the Centre's contract with FSCD in order to activate your file. If you still need additional information, this can be signed later in the application process.

_____ _____

Parent Signature Date