SPECIALIZED SERVICES APPLICATION

Office Use Only
Start Date: ____________
Team: ______________
Initials: ______________

Date of Application (mm/dd/yyyy) ____________________

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)	

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 BEHAVIOUR CASE MANAGER/OCCUPATIONAL THERAPIST/SPEECH-LANGUAGE PATHOLOGIST VISITS:
(check all the apply- √)

	MORNING	AFTERNOON	EVENING
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			

PLEASE NOTE: Evening availability is limited and you may be placed on a waitlist. The last available daytime appointment is 3pm and evening visits end at 630pm.

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

Last reviewed: April 2019

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		

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)____

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 in the past?

YES____NO____ If YES: Start Date___________________________ End date:______________________________

FSCD NUMBER	CASE WORKER'S NAME

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)	

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 **<u>CURRENTLY</u>** 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:
	Name:	Start date:	End date:
AGENCIES OR PROGRAMS YOUR CHILD HAS **<u>PREVIOUSLY BEEN</u>** INVOLVED IN	Agency/Program		
	Name:	Start date:	End date:
	Name:	Start date:	End date:

TEAM MEETINGS, HOME VISITS, and INTERVENTIONIST VISITS	
TEAM MEETINGS (MANDATORY)	Occur **4** times per year, on a Mon. Tues. Thurs. or Fri. starting no *earlier* than **10:30am** and no *later* than **3:00pm.** Occur at the Centre with all members of the team, including parent(s)/guardian(s).
CONSULTANT VISITS (MANDATORY)	Visits by your Clinical Team - Behavioural Case Manager, Occupational Therapist, Speech-Language Pathologist, or Clinical Supervisor. Your team may also include a Psychologist and a Physical Therapist, depending on need. These visits vary in frequency based on clinical need. Occur on weekdays, starting no earlier than **8:00am** and concluding no later than **6:30pm.** Exceptions will be made if necessary (for example - when doing bed time or wake-up routines). Occur in your home, community or at the Centre.

INTERVENTIONIST / AIDE VISITS (OPTIONAL)	Interventionists are **optional** and are placed when the team and family agree that an interventionist will improve services. If placed, the schedule is reviewed **every 3 months**. Due to capacity issues, after school shifts are generally reserved for school-aged children. Shifts occur in your home, daycare, at the Centre, or in the community. Shifts are 2-3 hours long and happen 1-5 times per week. Interventionists are supervised by team members and are placed based on family and team availability.

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)

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:

IN CASE OF EMERGENCY

In case of emergency and in my absence, I authorize by my signature below that the staff of the Centre for Autism Services Alberta, and its subsidiary programs, may give my child emergency care on site or transport them to an outside location. All medical aid, above and beyond first aid, will be administered by public emergency response teams and by qualified medical personnel only.

I give consent to Centre for Autism Services Alberta staff to arrange for any medical treatment and/or ambulance should it be required in the event of an illness or injury. I understand that payment for this service is my responsibility.

SIGNATURE____ DATE (mm/dd/yy)_______________________________

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