

# SPECIALIZED SERVICES APPLICATION

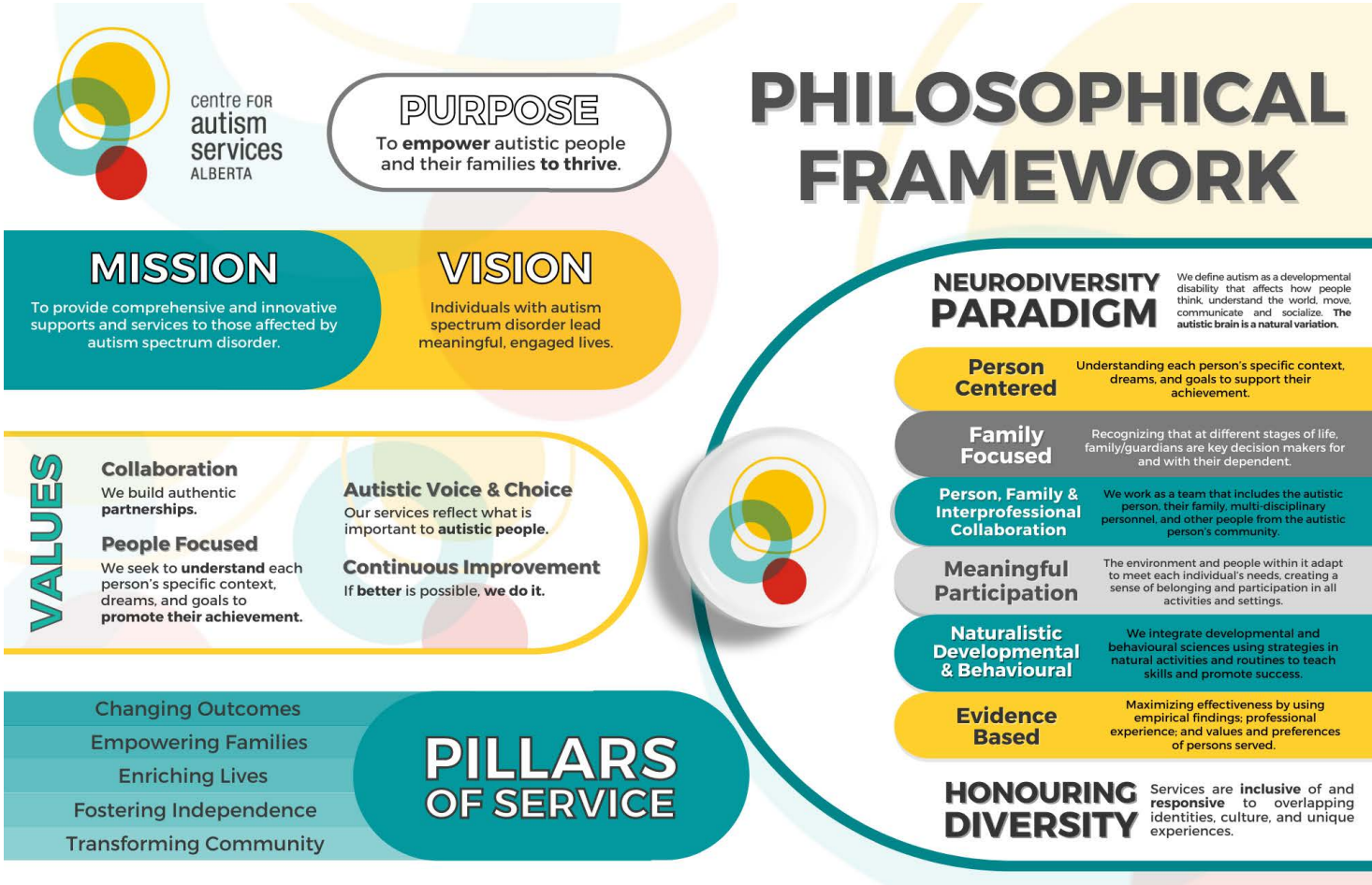
Office Use Only
Start Date: _____
Team: _____
Initials: _____

Date of Application (mm/dd/yyyy) \_\_\_\_\_

**Every child is unique. Every family is unique.** The Centre’s Specialized Services (SS) are focused to meet the unique needs of children and families affected by Autism Spectrum Disorders (ASD) and associated challenges. With 25+ years of experience, the Centre has developed a philosophy and approach that is holistic, inclusive, values children and families, and prioritizes strategies that work for you.

**Services are**

- Consultative
- Guided by evidence-based practices and follow FSCD regulation
- Delivered in the home and community. We come to you!
- Will include support for behaviour, communication/socialization and self-help
- May consist of psychology, physiotherapy, and aide support



<b>CHILD'S INFORMATION</b>					
CHILD'S LAST NAME			CHILD'S FIRST NAME		
GENDER (please choose 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)	
<b>FAMILY SUPPORT FOR CHILDREN WITH DISABILITIES (FSCD) INFORMATION</b>					
Have you been approved for Specialized Services (SS)?    Yes <input type="checkbox"/> No <input type="checkbox"/>				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		
<b>PARENT(S) / GUARDIAN(S) INFORMATION</b>					
1) PARENT/GUARDIAN NAME (First name, Last name)			2) PARENT/GUARDIAN NAME (First name, Last name)		
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
EMAIL ADDRESS			EMAIL ADDRESS		
OCCUPATION		PLACE OF EMPLOYMENT		OCCUPATION	
OCCUPATION		PLACE OF EMPLOYMENT		OCCUPATION	
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 that apply- √)			AVAILABILITY FOR STAFF VISITS: (check all that apply- √)		
	MORNING	AFTERNOON	EVENING		MORNING
MONDAY				MONDAY	
TUESDAY				TUESDAY	
WEDNESDAY				WEDNESDAY	
THURSDAY				THURSDAY	
FRIDAY				FRIDAY	
SATURDAY				SATURDAY	
SUNDAY				SUNDAY	
<b>LANGUAGE FLUENCY AND CULTURAL IDENTIFICATION IS USED TO HELP WITH STAFF PLACEMENT &amp; SUPPORT NEEDS</b>					
PRIMARY LANGUAGE SPOKEN			PRIMARY LANGUAGE SPOKEN		
OTHER LANGUAGES SPOKEN			OTHER LANGUAGES SPOKEN		

IF ENGLISH AS SECOND LANGUAGE: (select one) Little to none      Basic skills      Speak fluently Read English? (✓) Y      N      Write English? Y      N				IF ENGLISH AS SECOND LANGUAGE: (circle one) Little to none      Basic skills      Speak fluently Read English? (✓) Y      N      Write in English?			
IDENTIFIED CULTURE / RELIGION / ETHNICITY		LENGTH OF TIME IN CANADA		IDENTIFIED CULTURE / RELIGION / ETHNICITY		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:
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NAME OF PRESCHOOL(S) OR KINDERGARTEN(S)

Is your child <u>currently</u> in PUF?      YES      NO	NAME OF PRESCHOOL/KINDERGARTEN
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Will your child be PUF eligible this coming Sept?      YES      NO	NAME OF PRESCHOOL/KINDERGARTEN (if known)
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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
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GRADE	TEACHER NAME
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PROGRAM (Regular class, Interactions, Other, etc)

### OTHER AGENCIES

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

<b>AGENCIES OR PROGRAMS YOUR CHILD HAS <u>PREVIOUSLY BEEN INVOLVED IN</u></b>	Other agency/program names:		
	Name:	Start date:	End date:
	Name:	Start date:	End date:
	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 NUMBER	CELL PHONE NUMBER	RELATIONSHIP TO CHILD
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**CHILD'S HEALTH INFORMATION**

ALBERTA HEALTH CARE NUMBER	PHYSICIAN'S NAME	PHONE NUMBER
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/CHALLENGES TO SERVICE PLEASE NOTE:** selecting any of the following does **not** impact eligibility for services

Do you perceive any barriers/challenges to accessing services?

<b>CHECK ALL THAT APPLY</b>	<input checked="" type="checkbox"/>	<b>DESCRIBE FURTHER AS APPROPRIATE</b>
Language/communication	<input type="checkbox"/>	
Limited time	<input type="checkbox"/>	
Identify as low income	<input type="checkbox"/>	
Understanding the system	<input type="checkbox"/>	
Driving/Transportation	<input type="checkbox"/>	Do you drive/have access to transportation? YES NO
Competing demands (work, family, other)	<input type="checkbox"/>	
Other	<input type="checkbox"/>	
No barriers identified	<input type="checkbox"/>	Prefer not to answer

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

4752 – 99 Street, Edmonton, Alberta T6E 5H5 T 780.488.6600 F 780.488.6664  
E info@centreforautism.ab.ca www.centreforautism.ab.ca

Charitable Number 872973995 RR0001

