Application for Admissions

Thank you for your interest in Autumn's Dawn. This is the first step in your exciting Journey of New Beginnings. The information you provide us with in this application will help determine if you are good fit for Autumn's Dawn. Once the completed application is received, a representative of Autumn's Dawn will contact you to schedule an intake interview and any additional assessments.

Appropriate applicants should meet the following criteria:

- **Young adults age 18 - 30 diagnosed with an autism spectrum disorder**
- **Young adults whose intellectual functioning does not interfere with their ability to care for their personal needs**
- **Young adults who express a desire to be in control of their own lives and function independently within the community**
- **Young adults who know there is something more they need in order to live a productive and fulfilling life, but are not sure what step to take next**

A $100 processing fee will be due upon receipt of the application. Please make checks payable to Autumn's Dawn.

Application Checklist

____Personal Information Packet

____Most Recent Psycho-Educational Report *(from a qualified professional)*

____Application Interview *(conducted by Autumn's Dawn staff member)*

____$100 Application Fee

Personal Information Packet

Personal Information

Name:_____

Address:_____City:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

Date of Birth:_____

Gender:_____

Diagnosis:_____

Family Information

Father/Guardian
Name:_____

Address:_____City:_____Zip_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Place of
Employment:_____

Mother/Guardian
Name:_____

Address:_____City:_____Zip_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Place of
Employment:_____

Family Physician

Name:_____Address:_____

Home Phone:_____

Other Doctor(s)/ Counselors

Name:_____Phone:_____

Name:_____Phone:_____

Emergency Contact Information

Name(s):_____ Relationship to You_____

Address:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Your Marital Status: ___Single ___Married ___Divorced

Do you have any children? ___No ___Yes

If yes:

Name	Age	Where They Live (City, Town)

Siblings or Important Relatives in Your Life

Name	Age	Relationship to You	Where They Live (City, Town)

Educational Information

Name of High School:_____

City, State of School:_____

Dates Attended:_____

Date you Graduated or Plan to Graduate:_____

Name of Trade/Technical/Vocational School:_____

City, State of School:_____

Dates Attended:_____

Date you Graduated or Plan to Graduate:_____

Certificate Awarded: ___No ___Yes

Name of College or University:_____

City, State of College/University:_____

Dates Attended:_____

Major or Areas of Study:_____ Number of Hours:_____

Degree: _____

City, State of College/University:_____

Dates Attended:_____

Major or Areas of Study:_____ Number of Hours:_____

Degree: _____

Employment History (please include any job training experiences and internships)

Employer's Name:_____

Job Duties:_____

_____

_____

_____

Dates Employed:_____ Did you receive pay?_____

Reason for Leaving:_____

_____

Employer's Name:_____

Job Duties:_____

_____

_____

_____

Dates Employed:_____ Did you receive pay?_____

Reason for Leaving:_____

_____

Employer's Name:_____

Job Duties:_____

_____

_____

_____

Dates Employed:_____ Did you receive pay?_____

Reason for Leaving:_____

_____

Medical Information

Vision: Do you wear glasses? Yes____ No____ Sometimes____

Hearing: Do you wear any hearing aids? Yes___ No___

Do you need to use any adaptive equipment for physical activities? (Cane, crutches, wheelchair, walker, etc.) ___ No ____ Yes (if yes, what_____)

Do you require physical therapy? ____ No ____Yes, regularly ____Yes, occasionally

Do you have any difficulties over a 2 to 3 hour period with:

____ Walking ____ Grasping ____ Bending ____ Running ____Carrying ____ Stooping

____ Climbing ____ Pushing ____ Pulling ____ Other_____

Are there any time limits on physical activity? ____ Yes ____No

If yes, what kind and how long have they existed?_____

Are you allergic to any of the following things? Check all that are appropriate to you.

____ Environmental (Dust, Molds, Grass, Animals)

____ Medications (if so, which ones_____)

____ Foods (if so, what food(s)_____)

____ Other_____

What medications to you take (if any)?_____

_____

What side effects (if any) result from your medication(s)?_____

_____

Are there any limitations to your physical activity as a result of your medication(s)?_____

_____

Any special dietary needs? _____

Any critical medication information (ex. Migraines, seizures, etc.)_____

_____

Guardianship Statement

Complete either Section A or Section B:

Section A

Attached is a copy of a court-executed guardianship order declaring_____ to be the lawful guardian(s) of _____.

Guardian Printed Name:_____ Guardian Signature & Date:_____

Your Printed Name:_____ Your Signature & Date:_____

Section B

I, _____, am my own guardian.

Your Printed Name:_____ Your Signature & Date:_____

Release of Information

I, _____, allow Autumn's Dawn to release information concerning my programming to the following individuals:

Name:_____

Name:_____

Name:_____

Name:_____

Name:_____

*If I,_____, share the concern of bringing harm to myself or others, I understand the information will/must be shared with parent/guardian and the appropriate officials.

Client Signature

Request for and Authorization to Release Information

Autumn's Dawn offers and provides a holistic program of services to our clients. It is our responsibility to provide the highest quality services for each client by working closely with the individual, our staff, and other professionals, in obtaining all necessary and relevant information. This request for information serves both the purposes of establishing initial eligibility and as a foundation for ongoing services. As a result, Autumn's Dawn has presented this information and obtained our client's consent for its release:

- Assessment/Diagnostic Information and Reports
- Educational Information
- Work History Information
- Services/Treatment(s) Progress Notes
- Recommendation(s) for Ongoing Treatment(s)/Services

I, _____, give permission for Autumn's Dawn to contact_____ regarding the information listed above.

The purpose of this request for and authorization to release information has been explained to me thoroughly, and I have signed this form voluntarily.

Client Signature: _____Date: _____

Program Director's

Signature:_____Date:_____

Career Management Director's Signature: _____Date:_____

Media Consent Form

I hereby consent to the participation in interviews, photographs, and movies with the use of my name and my quotes. I grant Autumn's Dawn professional staff members the right to edit and then to exhibit the resulting media in all Autumn's Dawn publications and website content. I also release Autumn's Dawn and its employees, volunteers and other associates from any claims based on the use of said material and waive any right to inspect, approve or edit the material.

_____

Printed Name of Client

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

Client Code of Conduct

I, _____, agree to the following in order to be a client of Autumn's Dawn:

- treat others with respect and dignity. Verbal and/or physical abuse will not be tolerated.
- actively and willingly participate throughout the Autumn's Dawn process.
- work cooperatively with the Life Coach and all other Autumn's Dawn staff. If I choose to be uncooperative, my session may be discontinued for the day.
- attend all seminars as scheduled.
- attend scheduled Life Management Time, Career Management Time and/or Seminars. (Every attempt will be made to reschedule missed appointments; however, no credit will be made to the monthly tuition.
- refrain from using electronic devices (excluding phones) during Autumn's Dawn services.
- refrain from using illegal drugs, alcohol & tobacco.

Infractions will be reported to the Executive Director and reviewed by the Incident Review Committee.

_____ _____

Autumn's Dawn Client Date

_____ _____

Autumn's Dawn Center Staff Date