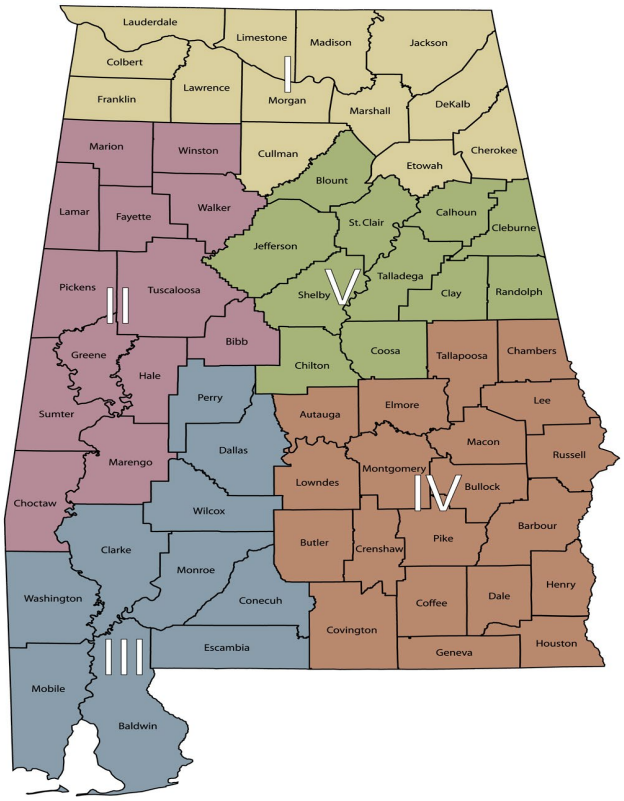
Instructions for completing the ADMH Autism Services Client Application

Please use this guide to help you through the application process. Check off each step as it is completed. Contact the Autism Intake Specialist at karmelia.brown@mh.alabama.gov or 800-499-1816 if you need assistance.

	1. Complete the application for ADMH Autism Services-please type or print legibly in black/ blue ink only
	2. Submit copies of the following documents with the application:
	a. Assessment of Autism Spectrum Disorder (Psychological Evaluation, Adaptive Skills testing, diagnostic report, Autism Confirmation Tool for Healthcare Providers)
	b. Comprehensive medical history and most recent physical/well visit screening
	c. Copy of reports describing the disability completed by schools attended or other services agencies (e.g. IEP, IFSP, 504 Plan, Speech/Language Report etc.)
	d. Copy of reports documenting involvement of child-serving agencies such as DHR, DYS, ADRS etc.
	e. Copy of discharge summary from inpatient/residential placement if applicable
	f. Copy of Social Security Card
	g. Copy of Medicaid Card
	h. Copy of Guardianship or Custody documents if applicable
	i. Authorization for Release of Information (requires signature) if you would like us to request/release records and or information from a specific agency
	j. Notice of Privacy (requires signature)
	3. Return the application and requested documents to the Intake Specialist at karmelia.brown@mh.alabama.gov or ADMH Autism Services 100 North Union Street Suite 350 Montgomery, AL 36130-1410

Once it is determined that all necessary documentation has been received, you will be contacted by your Regional Autism Coordinator to schedule a screening assessment.



Regional Autism Coordinators

Region I- Kelly Mason

Region II- Andrea McCoy

Region III- Deon Gatson

Region IV- Robyn McQueen

Region V- Cody Farmer

Application for ADMH Autism Services

If you need assistance completing this application, please contact the Autism Intake Specialist at karmelia.brown@mh.alabama.gov or call 800-499-1816 for assistance.

Applicant:

Name: _____
First Middle Last Preferred Name

Address: _____
Street Address

_____
City County State Zip Code

_____
Mailing Address if different

Telephone Number: _____ Date of Birth: ____/____/____

Social Security Number: _____/_____/_____ Medicaid Number: _____

Race/Ethnicity: _____ Gender: _____ Citizenship Status: _____

Marital Status: _____ Place of Birth: _____

Primary Contact: _____

Address: _____
Street Address

_____
City County State

Relationship to applicant: _____ Telephone Number: _____

Email: _____

Legal Status of Applicant (check all that apply):

____ Competent ____ Legally Incompetent (documentation required) ___ Minor N/A

Name of Legal Guardian, if applicable: _____

Address: _____
Street Address

_____
City County State

Relationship to Applicant: _____ Telephone Number: _____

Email: _____

Emergency Contact:

Name: _____

Telephone Number: _____ Email: _____

Referral Source:

Name: _____

Telephone Number: _____ Email: _____

Additional Information:

Primary Written/Oral Language: _____Interpreter Needed: _____

Adaptive Equipment Needed: _____ Mobility Needs: _____ Hearing Impaired: _____

Visually Impaired: _____ Allergies: _____

Active/Primary Diagnoses (documentation required): _____

Intellectual/Developmental Disability Diagnoses (documentation required): _____

Inpatient Hospitalization/Residential Out of Home Placement (documentation required): _____

_____

Other Medical Information: _____

Physician(s): _____

_____

_____

Check (✓) ALL Services the Applicant is Currently Receiving (documentation required):

___ Early Intervention ___Speech/Language Therapy ___Occupational Therapy

___Physical Therapy ___Behavior Supports ___Waiver

___ Case Management ___ Other

Check (✓) ALL Services the Applicant is Receiving or has Received in the last six (6) months from Other Agency(ies) (documentation required):

___ Department of Human Resources (DHR)

___ Department of Youth Services (DYS)

___ Alabama Department of Rehabilitation Services (ADRS)

___ Department of Mental Health (DMH)

___Alabama State Department of Education/Special Education (ALSDE) IEP or 504

If additional information is needed, the Intake Specialist will contact you to request additional information. Once the completed application packet, with all supporting documentation is received, a Regional Autism Coordinator will contact you and/or your family to schedule a screening assessment.

Service Needs: If deemed eligible, the following services may be available through ADMH Autism Services.

Intensive Care Coordination
Behavior Supports
In-Home Therapy
Therapeutic Mentoring
Peer Support-Youth
Peer Support-Family
Psychoeducational Services

Completed By:

Name: _____ Date: _____

Phone Number: _____ Email: _____

Relationship: _____Applicant ____Parent ____Guardian ___Other

*By submitting this form, I acknowledge I wish to apply for ADMH Autism Services on behalf of myself or my child.

I, _____, hereby authorize ADMH Autism Services to release information

regarding my application and treatment to: (Name and referral source agency ex. DHR Case Worker)

_____

_____

_____ _____
Parent/Guardian Date

_____ _____
Client if 14 or older Date

Please return this application and all supporting documentation to:

karmelia.brown@mh.alabama.gov

or

ADMH Autism Services
100 North Union Street, Suite 350
PO Box 301410
Montgomery, AL 36130