



## New LIFE STUDENT APPLICATION

DATE: \_\_\_\_\_ PERSON COMPLETING FORM: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Last

First

Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Ethnicity (for demographic purposes only): \_\_\_\_\_

*Please answer the following questions:*

Who is the applicant currently living with? \_\_\_\_\_

What is their relationship to applicant? \_\_\_\_\_

## FAMILY INFORMATION

Mother's or Guardian's Name:	Father' or Guardian's Name:
Address:	Address:
Best Contact Number:	Best Contact Number
Email Address:	Email Address:
Employer Name:	Employer Name:

Person Responsible for payment of fees:
Address if different than above:
Best contact number of responsible payer:
Email address:

## SIBLING INFORMATION

Name:	Age:	Address:	Phone:	Email

In case of emergency and unable to reach parents or guardians, please notify:

Name: \_\_\_\_\_

Best contact number: \_\_\_\_\_

## FUNDING AND BENEFITS

	SSI		Housing Assistance
	SSDI		Utility Discount
	Food Stamps		Other:
	Alabama Medicaid Waiver		Medicare/Medicaid

Has the applicant applied for Alabama Rehabilitation Services (ADRS)? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Please provide the rehabilitation counselor's name: \_\_\_\_\_

## GUARDIANSHIP

Does the Applicant have a Legal Guardian: Yes: \_\_\_\_\_ No: \_\_\_\_\_

If so, who is the Applicant 's Legal Guardian? \_\_\_\_\_

## EDUCATIONAL HISTORY

School(s) Attended & Address	Dates	Diploma/Certificate/Degree

What are the Applicant's areas of academic strength?

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What are the Applicant's areas of academic weakness?

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## VOCATIONAL HISTORY

Please list the two most recent work experiences, starting with the most recent:

Most recent Employer's name: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Position Filled: \_\_\_\_\_

Duties: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_

Type of Employment:

- Paid Competitive
- Non-paid internship
- Non-paid school/work experience
- Paid school experience
- Other:

If paid, what was the hourly rate of pay? \_\_\_\_\_ Number of hours worked per week? \_\_\_\_\_

Did participant receive job coach support? Yes: \_\_\_\_\_ No: \_\_\_\_\_

How was the position obtained? \_\_\_\_\_ ADRS \_\_\_\_\_ School System \_\_\_\_\_ Vocational Program  
\_\_\_\_\_ Family/Friend \_\_\_\_\_ Other: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

2nd Employer's name: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Position Filled: \_\_\_\_\_

Duties: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_

Type of Employment:

- Paid Competitive
- Non-paid internship
- Non-paid school/work experience
- Paid school experience
- Other:

If paid, what was the hourly rate of pay? \_\_\_\_\_ Number of hours worked per week? \_\_\_\_\_

Did participant receive job coach support? Yes: \_\_\_\_\_ No: \_\_\_\_\_

How was the position obtained? \_\_\_\_\_ ADRS \_\_\_\_\_ School System \_\_\_\_\_ Vocational Program  
\_\_\_\_\_ Family/Friend \_\_\_\_\_ Other: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

## MEDICAL HISTORY

Question	Yes	No	If yes, please describe:
Does the applicant have mobility of physical impairment?			
Is the individual blind or visually impaired?			
Is the applicant deaf or hearing impaired?			
Does the applicant drive?			Licensing state? <span style="float: right;">Permit?</span>
Does the applicant use public transportation?			
Does the applicant have an Alabama ID (non-driver)			

Name of Primary Care Physician: \_\_\_\_\_

Physician's Telephone: \_\_\_\_\_

**Applicant's Developmental History:**

Age at which symptoms were first observed: \_\_\_\_\_

Please describe: \_\_\_\_\_

At what age was professional help first sought? \_\_\_\_\_

What was the initial diagnosis? \_\_\_\_\_

Additional diagnosis? \_\_\_\_\_

Has the applicant ever been hospitalized for any reason? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please provide the reasons and dates:

\_\_\_\_\_

\_\_\_\_\_

Does the applicant take any prescription medications?: Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please provide details:

Medication:	Dosage:	Frequency:	Condition:

Please detail the applicant's ability to self-medicate:

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Does the applicant wear: Eyeglasses \_\_\_\_\_ Contact lenses \_\_\_\_\_

Does applicant wear hearing aids: Yes \_\_\_\_\_ No \_\_\_\_\_

Describe the impact on functioning from visual or hearing difficulties:

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Describe the impact on functioning related to any speech and language issues:

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Describe the impact on functioning related to any physical limitations:

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Does the applicant have allergies? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, describe allergies and any precautions: \_\_\_\_\_

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Does the applicant have any seizure disorders? Yes \_\_\_\_\_ No \_\_\_\_\_

Are seizures controlled by medication? Yes: \_\_\_\_\_ No: \_\_\_\_\_

When was the last time the applicant had a seizure? \_\_\_\_\_

Describe any other medical issues or concerns: \_\_\_\_\_

\_\_\_\_\_

## BEHAVIORAL HISTORY

Has the applicant	Yes	No
Been suspended from school?		
Been arrested?		
Had any legal problems or current litigation?		
Abused alcohol?		
Abused drugs?		
Been physically, sexually, or emotionally abused?		
Presented a danger to self or others?		
Been hospitalized for problems related to emotions, behavior, drugs, or alcohol?		
Smoked cigarettes?		
Acted out when angry or distressed?		
Had difficulties telling the truth consistently?		
Committed theft?		
Had any traffic/driving violations?		

If you have checked "Yes" for any item above, please provide us with some information about the

behavior: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Describe the applicant's current behavioral strengths and weaknesses:

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## SOCIAL INFORMATION

What are the applicant's main interests or hobbies?

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<b>Does the applicant:</b>	<b>Yes:</b>	<b>No:</b>
Make friends easily?		
Interact comfortably with peer group?		
Make friends in his/her own age group?		
Regularly choose to spend time with peers?		
Regularly phone, text, or email others?		
Use social network sites on the internet?		
Show interest in dating?		
Have difficulty discerning appropriate vs inappropriate social behavior?		

Please describe the applicant's social strengths and weaknesses:

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Please identify any concerns and or safety risks that you are aware of in the following

categories:Independent

Living: \_\_\_\_\_

Employment: \_\_\_\_\_

Social Situations: \_\_\_\_\_

Educational: \_\_\_\_\_

What are your immediate goal in working with the **LIFEE** program?

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## REFERRAL INFORMATION:

How did you hear about us? \_\_\_\_\_

## STUDENT FIELD TRIPS:

Students will be taking field trips during Arts 'n Autism's LIFEE Program. These trips are planned to enrich the curriculum. All trips are well organized and supervised. Prior to trips, your participant will receive details of the trip including the place and what they will need to participate.

*I agree that \_\_\_\_\_ should be allowed to participate in these field trips and understand that the students will be instructed in the rules of safety for these trips and that every safety precaution will be taken by the staff.*

*In the case of an accident, injury, or illness, I permit my child to be given emergency treatment at the nearest medical facility, and I will be responsible for all costs involved. I understand all measures will be taken to contact me if emergency care is required.*

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## PERMISSION TO TRANSPORT

I, \_\_\_\_\_, do hereby freely grant the Arts 'n Autism LIFEE program permission to transport (in the Arts 'n Autism bus or a contracted bus) my child \_\_\_\_\_ to and from any and all locations within the Tuscaloosa metro area to attend activities planned by the Arts 'n Autism LIFEE program.

I further release the Arts 'n Autism LIFEE Program from any and all claims for any injuries that could be sustained directly or indirectly during the transport of my child.

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Parent/Guardian Signature

Date

## SAFETY SEAT ADDENDUM

I, \_\_\_\_\_, do freely grant the Arts 'n Autism LIFEE program to transport ( in the bus owned by Arts 'n Autism or a contracted bus) my child, \_\_\_\_\_.

I understand that my child will be securely buckled in with a seat belt in the bus or a contracted bus.

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Parent/Guardian Signature

Date

## SOCIAL LIFEE WAIVER

By signing below you signify that you are aware that social activities such as Social LIFEE nights coordinated by LIFEE or LIFEE participants are extracurricular in nature and an outside activity for which Arts 'n Autism and the LIFEE program assumes no liability. You agree to hold harmless Arts 'n Autism, the LIFEE program, all staff, and directors for any occurrence of injury that may be sustained during any of these events.

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Parent/Guardian Signature

Date

## FINANCIAL RESPONSIBILITY

*I AGREE TO PAY THE FULL AMOUNT OF MY CHILD'S TUITION FOR THIS SEMESTER LESS ANY*

*FINANCIAL ASSISTANCE AWARDED. I understand such assistance can be awarded through ADRS funding, grant funding, or private scholarship assistance. I also understand that the amount of awardable scholarships is limited and are awarded based on financial need and parent/student participation. I agree that if awarded Arts 'n Autism funding I agree to satisfy volunteer commitments commensurate with the amount awarded in tuition based on an agreed upon hourly rate. I agree to fill out an application for financial aid if such assistance is needed **and** I meet the requirements.*

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Parent/Guardian Signature

Date

Please fill out and sign the following if another party is responsible for paying the applicant's bill.

I, \_\_\_\_\_, agree to pay \_\_\_\_\_ % of  
\_\_\_\_\_ 's tuition bill.

Home Address: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## EMERGENCY TREATMENT RELEASE

*In the event of an accident, injury, or illness, I permit my child \_\_\_\_\_ to be given emergency treatment at the nearest medical facility, and I will be responsible for all costs involved. I understand that all measures will be taken to contact me if emergency care is required.*

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Parent/Guardian Signature  
Date

## PHOTOGRAPH/VIDEOTAPE RELEASE

*I, \_\_\_\_\_ do hereby freely grant the Arts 'n Autism LIFEE program permission to photograph and videotape my child for public relations in any media, including but not limited to : the Arts 'n Autism website, Facebook, Instagram, Arts 'n Autism promotional material and local news and/or media. I further release the Arts 'n Autism LIE£ program from any and all claims for damages for libel, slander, invasion of the right to privacy, and any other claims based on, arising out of or connected with the use of such photographs/videotapes.*

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Parent/Guardian Signature

Date

## DEMOGRAPHIC INFORMATION

(Optional; we use this information for statistics and grant funding only)

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Language spoken in home

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Ethnic origin

Family structure:

\_\_\_\_\_ 2 parent household

\_\_\_\_\_ 1 parent household

\_\_\_\_\_ Foster

\_\_\_\_\_ Other: \_\_\_\_\_

Household income:

\_\_\_\_\_ Less than \$15,930/year

\_\_\_\_\_ More than \$15,930/year

\_\_\_\_\_ Number in household

Revision: 10/28/2020