

Asperger's Association of New England

LifeMAP - Application Form

Date: _____

APPLICANT INFORMATION

Last Name	First	M.I.	Date Of Birth:
Street Address			Apartment/Unit #
City	State	ZIP	
Phone #	Cell Phone #		
Email Address			
Are You Currently: Working <input type="checkbox"/> yes <input type="checkbox"/> no In School <input type="checkbox"/> yes <input type="checkbox"/> no Other (please specify):			
Are You Living: <input type="checkbox"/> With Parents <input type="checkbox"/> On Your Own <input type="checkbox"/> With Spouse Other (please specify):			
Do You Drive? <input type="checkbox"/> yes <input type="checkbox"/> no			
Ethnicity: <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> Black (non-Hispanic) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other (please specify)			
What is your annual income? \$ Does your family or someone else help supplement your income? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, indicate approximate annual amount: \$			

DIAGNOSIS & TREATMENT

Please Indicate Present Diagnosis: <input type="checkbox"/> Asperger's Syndrome <input type="checkbox"/> High Functioning Autism <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Pervasive Developmental Disorder - Not Otherwise Specified			
Diagnosis Made By		Age At Diagnosis	
Street Address			
City	State	ZIP	
Phone #	May we speak with your Dr. ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please Check Off Any Benefits / Services You Are Receiving:			
<input type="checkbox"/> SSI	<input type="checkbox"/> Common Health	<input type="checkbox"/> MRC	<input type="checkbox"/> Mass Health
<input type="checkbox"/> SSDI	<input type="checkbox"/> DDS (DMR)	<input type="checkbox"/> DMH	<input type="checkbox"/> Other (specify):
Are you working with other professionals such as a therapist, coach, case manager, speech therapist, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES please indicate the setting: <input type="checkbox"/> Group <input type="checkbox"/> Individual If YES please indicate name(s) and specialty:			
1. _____			
Last Name:		First Name:	Specialty:
2. _____			
Last Name:		First Name:	Specialty:
Do you have a Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of your last Primary Care appointment?			

Asperger's Association of New England

LifeMAP - Application Form

Date: _____

GOALS

Name 1 or 2 things you would like assistance with:
(setting up systems to pay bills, managing appointments, organizing living space, accessing social opportunities, filling out forms, etc.)

1.

2.

HISTORY (Conviction will not disqualify any applicant from participating in this program.)

Have you ever been convicted of a felony? Yes No

If YES, explain the number of convictions, nature of the offense(s) and how recently such offense(s) was/were committed;

STATEMENT OF TRUTH

I certify that information contained in this application is true and complete. I understand that false information may be grounds for not accepting me to participate or for immediate termination of participation in this program. I authorize the verification of any or all information listed above.

Signature of Client:

Date:

Signature of person completing application:
(if other than client)

Date:

AANE

LifeMAP Application Rev 09.08