**Hello from UA-ACTS!**

We are so pleased that you are interested in our program! As you know, this program is designed to support the successful transition of students with Autism Spectrum Disorders into The University of Alabama and throughout their college years. We ask all applicants to complete the attached information as an initial description of the prospective student’s strengths and weaknesses in the areas of academic organization, social skills, daily-living skills, etc. Completion of this application is the first step in admission to UA-ACTS, but there are other steps to complete before full admission to the program. Specifically, each student in consideration for admission to UA-ACTS must also:

1. Be admitted to The University of Alabama (you may do this while you are applying to UA-ACTS, but be aware formal admission into the program can only occur once the student has been admitted to UA).
2. Provide a letter from someone who works with this student in an academic setting. This letter must outline the student’s strengths and weaknesses as well as the ways this individual could benefit from the services provided by the program. (see attached Teacher Recommendation Form).
3. Once all application materials have been submitted, schedule an in-person interview with the student and at least one parent/caregiver (to be completed by February 1st).
4. Provide documentation and records regarding diagnosis, treatment history, and IQ and achievement testing (see the UA-ACTS website for requirements to document a diagnosis of an ASD at UA).

Please note that applications for UA-ACTS are reviewed beginning February 1st in the year that the student wishes to seek admission. Deadlines for admission to The University of Alabama, applications for housing and financial aid, etc. are set by the University and are subject to change. Please contact the Admissions Office at 1-800-933-BAMA or visit [http://gobama.ua.edu](http://gobama.ua.edu/) for more information.

We encourage all students who are considering The University of Alabama and UA-ACTS to complete a guided campus tour, and this can be done on the same day that the in-person interview is conducted. You may schedule these tours online or by phone with the University Admissions office.

We are happy to answer any questions you have regarding our program at any time, and you may call (205-348-9133) or email ([ua-acts@ua.edu](mailto:ua-acts@ua.edu)) for additional information.

We look forward to hearing from you soon!

Sincerely,



Megan Benson Davis, Ph.D.

Program Director, UA-ACTS

To Whom It May Concern:

The student who provided this form to you is applying for admission to the University of Alabama Autism Spectrum Disorders College Transition Support Program (UA-ACTS). This program is a campus based program that provides supports to students with a diagnosed Autism Spectrum Disorder at The University of Alabama. In order to determine how well a student fits with the program, we need to get information from multiple individuals who have worked with the student. We request that the enclosed form be completed and returned to the program by someone who has worked with the student in an academic setting.

Please be aware that we are not looking for students who have no notable difficulty as these students would not require our services. We are most interested in whether or not we can meet the needs the student has in order to continue to build on the student’s strengths, while helping them grow in the areas they have difficulty. We appreciate your time and feedback!

Sincerely,



Megan Benson Davis, Ph.D.

Program Director, UA-ACTS

**TEACHER RECOMMENDATION FORM**

**Student’s Name: Teacher’s Name:**

How do you know this student and how long have you worked with him/her?

ACADEMICS:

What academic strengths does this student have?

What academic areas does the student need the most assistance in?

What academic tasks do you believe this student will need help with in a college setting?

SOCIAL:

What extracurricular activities does this student participate in?

Please describe any difficulty this student may have interacting with peers in the classroom (e.g., group work, participating in discussions, etc.).

Overall, what services do you think this student will need at the college level to assist him/her in making the transition in regards to social skills and coping skills? Please be specific.

Please list any additional comments or concerns you may have regarding this student in the space below.

Please return this form to the following address:

The University of Alabama

ASD Clinic/UA-ACTS Program

Box 870161

Tuscaloosa, AL 35487-0161

**Application for Admission to UA-ACTS**

(CONFIDENTIAL)

**\*Application Instructions\***

**In order to ensure that all of your information and your student’s information is protected, we ask that you not use your child’s name after Page 1. All identifying information about your student should be on this page. On the remaining pages, please refer to your student as he/she, my student, or my son/daughter/grandson/etc. This will allow our admissions committee to provide a “blind” review of all applications.**

*Information about the STUDENT*

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Gender: | Male  Female |
| Date of Birth: | Click here to enter a date. | Phone Number: |  |

|  |  |
| --- | --- |
| Email Address: |  |

*Information about the Family/Caregivers*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Parent/Caregiver(s) Name(s): | | | | | |  | | | | | | | |
| Home Mailing Address: | | | |  | | | | | | | | | |
| Phone Numbers: | | Preferred: | | |  | | | Home  Cell  Work | | Alternate: | |  | Home  Cell  Work |
| Alternate: | | |  | | | Home  Cell  Work | | Alternate: | |  | Home  Cell  Work |
| Email 1: |  | | | | | | | | Email 2: | |  | | |
| Siblings (please include names and ages): | | | | | | |  | | | | | | |
| Current School Name: | | | |  | | | | | | | | | |
| School Address: | | |  | | | | | | | | | | |

**Student Status:**

Incoming Freshman

Expected Date of Graduation:

Current High School GPA:

***or***

Transfer Student

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Previous College/University: | | | |  | | |
| Student Year at UA: | | | Freshman  Sophomore  Junior  Senior  Unknown | | | |
| Reason for Transfer: | |  | | | | |
| College GPA: |  | | | | Previous Major: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anticipated UA Start Date: | Fall of  Summer of       *(If you are admitted to UA-ACTS you have the option of beginning over the summer rather than waiting until fall)* | | | |
| ACT/SAT Score: | |  | | |
| Has student been accepted to UA? | | | Yes  Application Pending  Have Not Applied | |
| Has student applied for housing? | | Yes  No | | |
| Has student applied for disability services at UA? | | | | Yes  No |

**Diagnostic History (please attach copies of relevant documents, including evaluation reports):**

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Diagnosis: | Autism  Asperger’s Syndrome  PDD-NOS  Other: | Age at time of ASD Diagnosis: |  |
| Name and title of professional who made that diagnosis: |  | | |
| Additional Diagnoses:  (e.g., ADHD, Anxiety, Depression, Math Disorder, Dysgraphia) |  | | |
| Date of most recent evaluation: |  | | |
| Tests/Measures Administered: |  | | |
|  |  | | |

**Intervention History:**

|  |  |  |  |
| --- | --- | --- | --- |
| Past and Present Interventions | Type of Professional | Targeted Issues | Dates/Frequency |
| Individual Counseling |  |  |  |
| Group Therapy/Counseling |  |  |  |
| Speech Therapy |  |  |  |
| Occupational Therapy |  |  |  |
| Physical Therapy |  |  |  |
| Other: |  |  |  |

**Medical History:**

Please list any significant medical concerns for the student, including allergies, past or current conditions, etc.:

Please list any medications that the student currently takes on a regular basis:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Condition for which it is  prescribed | Length of time on  medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the student take medications independently? | | Yes  No | |
| How does the student remember to take medications and organize his/her medicine? | | | |
|  | | | |
| Does the student refill prescriptions independently? | | | Yes  No |
| Prescribing Physician: |  | | |
| Contact Number: |  | | |
| Address: |  | | |
| Type of Physician: | Psychiatrist  General Physician  Other: | | |
| Will the above physician continue to prescribe medications once the student begins at UA? | | | |
| Yes  No  Undecided | | | |
| Are you interested transferring these prescriptions to a psychiatrist at the UA Student Health Center? | | | |
| Yes  No  Undecided | | | |

**Educational History (please attach copies of relevant documents, including IEP, transcripts, etc.):**

|  |  |  |
| --- | --- | --- |
| Current Academic Accommodations: |  | |
| Academic Strengths/Best Subjects: |  | |
| Academic Weaknesses/Difficult Subjects: | |  |
| Please briefly describe the student’s study skills and habits: | | |
|  | | |
| Please describe any supports you are providing as a parent/guardian to assist the student with schoolwork (e.g., checking homework, organizing projects, monitoring assignment due dates, creating planner/calendar, etc.): | | |
|  | | |

**Information Regarding Adaptive Skills:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Has this student ever worked a job outside of the home? | | | | | | | | | | Yes  No | | | |
| If yes, please describe the type of job, the responsibilities involved, and the strengths and weaknesses the student exhibited at the job site: | | | | | | | | | | | | | |
| Does the student: | | | | | | | | | | | | |  |
|  | Have and use a cell phone? | | | | Yes  No | | | | | | | | |
|  | Check voicemail on his/her cell phone? | | | | | | | | Yes  No | | | | |
|  | Have and use a computer? | | | | Yes  No | | | | | | | | |
|  | Will he/she bring a computer to campus? | | | | | | | | | | Yes  No | | |
|  | Have and use an email account? | | | | | Yes  No | | | | | | | |
|  | How frequently does the student check email (without being prompted)? | | | | | | | | | | | |
|  | Use a planner, smartphone, or electronic calendar to keep track of his/her schedule? | | | | | | | | | | | | Yes  No |
|  | Have a driver’s license? | | Yes  No | | | | | | | | | | |
|  | Will he/she bring a car to campus? | | | | | | | Yes  No | | | | | |
|  | Use public transportation? | | | Yes  No | | | | | | | | | |
|  | Have a checking account? | | | Yes  No | | | | | | | | | |
|  | Use a debit card? | Yes  No | | | | | | | | | | | |
|  | Wash and dry their clothes? | | | Yes  No | | | | | | | | | |
|  | Cook (using a microwave, oven, or stove)? | | | | | | Yes  No | | | | | | |
|  | Shop for clothing, food, or toiletries independently? | | | | | | | | | | | Yes  No | |
| Additional Information/Elaboration regarding the questions above: | | | | | | | | | | | | | |

Please briefly describe the areas related to self-care and independent living that this student will need the most assistance with:

Please describe supports that are currently provided to assist the student with daily-living skills (e.g., doing laundry, reminding to shower, administering medications, etc.):

**Information Regarding Social Interactions:**

What extracurricular activities is this student involved in?

What are the student’s strengths in the area of social interactions?

What social skills does the student struggle with?

**Miscellaneous Information:**

What are the student’s goals for college and for a career?

Please describe what this student does in his/her free time.

What services offered by the UA-ACTS program do you think will be most valuable for the student?

**Please use the remaining space to provide any additional information regarding the student, this application, etc.**

**Please Return the Completed Application and Supporting Documents to:**

**The University of Alabama**

**ASD Clinic/UA-ACTS Program**

**Box 870175**

**Tuscaloosa, AL 35487-0175**

**Or Email to:** [**ua-acts@ua.edu**](mailto:ua-acts@ua.edu)