



Quality Services For
Individuals With Autism

OFFICIAL USE ONLY	
Application Received:	_____
Approved for Services:	_____
Initial Point of Contact:	_____
Pre-Admission:	
___	Application for Services
___	Medical Exam/Special Admission Requirement
___	Service(s) Admission Assessment

P. O. Box 2487, Albemarle, NC 28002
704-982-9600 704-982-8155 (fax)

Application for Services

Notice: By signature below, I/we are voluntarily requesting services from GHA, Inc. and understand that consideration will be given to this Application for Services without regard to race, color, or national origin.

This Application for Services is being completed by: _____

Relationship to the applicant: _____ Date: _____

Parent, Individual, or Legally Responsible Person:

Printed Name: _____ Signature: _____

Printed Name: _____ Signature: _____

IDENTIFYING INFORMATION

Individual's Name: _____
First Middle Last Preferred

Gender: _____ Date of Birth: _____ Referred by: _____

Current Address: _____

Primary Phone # () _____ Alternate Phone # () _____

Medicaid # _____ Social Security # _____

If applicable, Medicare # _____ Prescription Drug Plan _____

If applicable, any additional third party coverage _____

List all services this individual is currently receiving: _____

List all previous services this individual has received:

Service Type/Location	Length services were provided	Reason(s) services were discontinued
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Comments: _____

LEGAL INFORMATION

Guardianship Status

Own guardian Minor/Custodian General guardian Limited guardian Power of Attorney Guardian(s) of the Person

Name of guardian(s) _____ Qualification Date: _____

Successor guardian preference, if known _____

Special needs trust established? No Yes _____

Pre-need Burial established? No Yes _____

Final Planning if known or established: _____

SOCIAL/FAMILY

Mother

Name: _____ DOB: _____ Place of Birth: _____

Address: _____

_____ E-mail: _____

Primary Phone # () _____ Alternate Phone # () _____

Occupation: _____ Social Security # _____

Father

Name: _____ DOB: _____ Place of Birth: _____

Address: _____

_____ E-mail: _____

Primary Phone # () _____ Alternate Phone # () _____

Occupation: _____ Social Security # _____

Siblings

Name	Date of Birth	Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Significant Persons

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____

Family Medical History

Respiratory (e.g. Asthma, Allergies, Cystic Fibrosis, Tuberculosis, etc)
 No Yes _____ Relationship to individual _____

Cardiovascular (e.g. Heart disease, Hypertension, etc)
 No Yes _____ Relationship to individual _____

Endocrine (e.g. Diabetes, Thyroid Disease, etc)
 No Yes _____ Relationship to individual _____

Gastro-Intestinal (e.g. Ulcers, Bowel difficulties, etc)
 No Yes _____ Relationship to individual _____

Urinary (e.g. Kidney problems, etc)
 No Yes _____ Relationship to individual _____

Neoplastic (e.g. Cancer, Tumors, etc)
 No Yes _____ Relationship to individual _____

Neurological (e.g. Stroke, Migraines, Developmental Disability, Seizures, Alzheimer's, Cerebral Palsy, etc)
 No Yes _____ Relationship to individual _____

Psychiatric (e.g. Depression, Bi-Polar, Schizophrenia, Anxiety, ADHD, Substance Abuse, etc)
 No Yes _____ Relationship to individual _____

Additional Comments: _____

DEVELOPMENTAL INFORMATION

Pre-Natal. Please indicate any concerns which occurred during pregnancy: _____

Labor & Delivery.

Pre-mature _____
 Caesarean Section Breech. Other information regarding labor & delivery: _____

Birth Weight: _____

Developmental Milestones. As closely as you can recall, please write the age when he/she did the following:

Started solid foods _____ Fed self with utensils _____ Rolled over _____ Stood _____
 Crawled _____ Walked _____ Bladder trained _____ Bowel trained _____ Dressed _____

When did you first think something was wrong with your child? _____

When did it seem serious enough to seek professional help? _____

Indicate whether or not he/she can:	Yes	No
Sort by size.....	<input type="checkbox"/>	<input type="checkbox"/>
Sort by color.....	<input type="checkbox"/>	<input type="checkbox"/>
Sort by function.....	<input type="checkbox"/>	<input type="checkbox"/>
Correctly spell/write name.....	<input type="checkbox"/>	<input type="checkbox"/>
Count 10 or more objects.....	<input type="checkbox"/>	<input type="checkbox"/>
Tell time on the hour.....	<input type="checkbox"/>	<input type="checkbox"/>
Tell time on the half hour.....	<input type="checkbox"/>	<input type="checkbox"/>
Understand functional signs (exit, bathrm, etc)...	<input type="checkbox"/>	<input type="checkbox"/>
Do simple addition & subtraction.....	<input type="checkbox"/>	<input type="checkbox"/>
Read/comprehend simple sentences.....	<input type="checkbox"/>	<input type="checkbox"/>
Read/comprehend newspaper or magazines...	<input type="checkbox"/>	<input type="checkbox"/>
Understand meaning of "no".....	<input type="checkbox"/>	<input type="checkbox"/>
Understand one-step directions.....	<input type="checkbox"/>	<input type="checkbox"/>
Understand multi-step directions.....	<input type="checkbox"/>	<input type="checkbox"/>
Ask a simple question.....	<input type="checkbox"/>	<input type="checkbox"/>
Relate experience when asked.....	<input type="checkbox"/>	<input type="checkbox"/>
Tell a story, joke, or plot.....	<input type="checkbox"/>	<input type="checkbox"/>
Describe realistic plans in detail.....	<input type="checkbox"/>	<input type="checkbox"/>
Identify currency.....	<input type="checkbox"/>	<input type="checkbox"/>
Make simple purchases.....	<input type="checkbox"/>	<input type="checkbox"/>
Make correct change.....	<input type="checkbox"/>	<input type="checkbox"/>
Use checking/savings account.....	<input type="checkbox"/>	<input type="checkbox"/>

Indicate the level of assistance he/she needs to:

Bathe/shower

- None (can do on his/her own)
- Minimal assistance such as verbal reminders or gesture prompts
- Partial assistance – needs some hands-on guidance
- Complete assistance – needs full support of others

Feed him/herself

- None (can do on his/her own)
- Minimal assistance such as verbal reminders or gesture prompts
- Partial assistance – needs some hands-on guidance
- Complete assistance – needs full support of others

Brush Teeth

- None (can do on his/her own)
- Minimal assistance such as verbal reminders or gesture prompts
- Partial assistance – needs some hands-on guidance
- Complete assistance – needs full support of others

Dress him/herself

- None (can do on his/her own)
- Minimal assistance such as verbal reminders or gesture prompts
- Partial assistance – needs some hands-on guidance
- Complete assistance – needs full support of others

Participate in household chores

- None (can do on his/her own)
- Minimal assistance such as verbal reminders or gesture prompts
- Partial assistance – needs some hands-on guidance
- Complete assistance – needs full support of others

Basic meal preparation

- None (can do on his/her own)
- Minimal assistance such as verbal reminders or gesture prompts
- Partial assistance – needs some hands-on guidance
- Complete assistance – needs full support of others

Developmental Information . . . continued

How does he/she get his/her message across to others? Answer the following and provide specific examples for "yes" answers.

Does he/she make requests for things that he/she wants/desires? No Yes

Does he/she make requests for things that he/she needs? No Yes

Is he/she able to reject or refuse things that are undesirable? No Yes

Is he/she able to gain the attention of others? No Yes

Is he/she able to make or provide comments? No Yes

Is he/she able to give information (observations about things which might not be readily known)? No Yes

Is he/she able to seek information from others? No Yes

Does he/she engage in any social routines? No Yes

Additional Comments: _____

How does he/she understand what is being communicated to him/her? Mark all that apply and give examples.

Understands what is said to him/her _____

Understands gestures _____

Understands signs _____

Understands/uses special system (e.g. pictures, word cards, objects, schedule board, etc) _____

Additional Comments: _____

Developmental Information . . . continued

Please indicate how often, if ever, the individual does the following behaviors:

	Never	Not this year	Less than once a month	About once a month	About once a week	Several times a week	Once a day or more
Has a tantrum or emotional outburst.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Damages own or others' property.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Disrupts others' activities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Bites him/herself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Scratches/pinches him/herself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Hits him/herself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Bangs his/her own head.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Bites others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Scratches/pinches others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Hits others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Kicks others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Runs or wanders away.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Steals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Eats/mouths inedible items.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						
Displays sexually inappropriate behavior...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Comments)</i>	<hr/>						

Additional Comments: _____

MEDICAL INFORMATION

Allergies. Please indicate any food, drug, or environmental allergies along with reaction(s)

(Allergy)	(Reaction)
(Allergy)	(Reaction)
(Allergy)	(Reaction)

Medical Hospitalizations & Surgeries.

(Date)	(For)
(Date)	(For)
(Date)	(For)

Psychiatric Hospitalizations/Crisis Stabilization.

(Date)	(Comments)
(Date)	(Comments)

Current Medications. Please list all current prescription medications he/she takes

Medication Name	Instructions	Prescribed For

Continue to back side if needed

Previous Medications. Please list any previous medications he/she has taken: _____

Which of the following best describes the level of support he/she needs to take prescription medications:

- Independent – the individual is totally responsible for his/her medication
- Assistance – staff/others keep medication; the individual participates with assistance
- Total Support – staff/others assumes total responsibility

Please indicate any health care issues he/she may be prone to develop (headaches, seasonal allergies, constipation, etc.)

(Condition)	(How is it usually treated?)
(Condition)	(How is it usually treated?)
(Condition)	(How is it usually treated?)

How does he/she indicate that he/she may not be feeling well?

Medical Information . . . continued

Hearing.

- Undetermined
- Normal
- Mild loss
(difficulty hearing normal speech)
- Moderate loss
(difficulty hearing loud speech)
- Severe loss
(can only hear amplified speech)
- Profound loss

Vision.

- Undetermined
- Normal
- Moderate impairment
(trouble seeing distances, curbs, etc)
- Severe impairment
(cannot see faces, line on which to write or mark)
- Light perception
(sees only light and/or shadows)
- Blind

Mobility.

- Walks independently
- Walks independently, but with difficulty
- Walks independently with corrective device.
- Walks only with assistance from another person.
- Does not walk.

Additional comments regarding hearing, vision, or mobility: _____

Sleep Habits.

He/she typically sleeps: All night 3-5 hours a night Less than 3 hours a night
 He/she uses: A standard bed An adapted bed Bed rails
 He/she prefers: A room alone A room with others
 Additional comments regarding sleep habits: _____

Is he/she on a special diet? No Yes _____

Does he/she require staff that are trained in special health care procedures? No Yes _____

Medical Concerns.

Respiratory (e.g. Asthma, allergies, Cystic Fibrosis, Tuberculosis, etc)

No Yes _____

Cardiovascular (e.g. Heart disease, Hypertension, etc)

No Yes _____

Endocrine (e.g. Diabetes, Thyroid Disease, etc)

No Yes _____

Gastro-Intestinal (e.g. Ulcers, Bowel difficulties, etc)

No Yes _____

Urinary (e.g. Kidney problems, etc)

No Yes _____

Neoplastic (e.g. Cancer, Tumors, etc)

No Yes _____

Neurological (e.g. Stroke, Migraines, Developmental Disability, Alzheimer's, Cerebral Palsy, etc)

No Yes _____

Seizures No Yes – Describe typical seizures: _____

Frequency of seizures: None during the past year Less than once a month Once a month About once a week
 Several times a week Once a day or more

Psychiatric (e.g. Depression, Bi-Polar, Schizophrenia, Anxiety, ADHD, Substance Abuse, etc)

No Yes _____

Current Primary Physician: _____ Practice Name: _____

Address: _____

Primary Phone # () _____ Fax # () _____

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION -Psychological evaluation (preferable TEACCH evaluation) – Social History – Medical History – Educational History – Other information as appropriate



Quality Services for Individuals with Autism

www.ghainc.org

704-982-9600 - 704-982-8155 (Fax)

Please do not fax completed applications.



