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

Regional Office
P. O. Box 4122, Wilmington, NC 28406
910-399-1683 910-399-1780 (fax)

OFFICIAL USE ONLY
Application Received: _____
Approved for Services: _____

Application for Services

PLEASE PRINT OR TYPE INFORMATION CLEARLY

Please select service(s) being requested: ☐ Residential ☐ Day Services ☐ Supported Employment

☐ Specialized Case Consultative Services

IDENTIFYING INFORMATION

Individual's Name _____
First Middle Last Preferred

Gender _____ Date of Birth _____ Social Security # _____

Medicaid # _____ Medicaid County of Origin _____

If applicable, Medicare # _____ Prescription Drug Plan _____

If applicable, any additional third party coverage _____

List all services currently receiving _____

_____

_____

Innovations Waiver Funding? ☐Yes or ☐ No
Managed Care Organization (MCO) associated with? _____

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: _____

Current Address: Street or PO Box: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

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

Occupation: _____

Father

Name: _____ DOB: _____

Current Address: Street or PO Box: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

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

Occupation: _____

Siblings

Name	Date of Birth	Contact Number

Other Significant Persons

Name	Relationship	Contact Number

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 _____

At what age was your child diagnosed with Autism Spectrum Disorder? _____

When did you first seek professional help? _____

_____

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

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……..	☐	☐	☐	☐	☐	☐	☐
(Comments)							
Damages own or others' property……	☐	☐	☐	☐	☐	☐	☐
(Comments)							
Disrupts others' activities……..	☐	☐	☐	☐	☐	☐	☐
(Comments)							
Bites him/herself……	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Scratches/pinches him/herself……	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Hits him/herself……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Bangs his/her own head……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Bites others……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Scratches/pinches others……	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Hits others……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Kicks others……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Runs or wanders away..……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Steals……..……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Eats/mouths inedible items……..	☐	☐	☐	☐	☐	☐	☐
((Comments)							
Displays sexually inappropriate behavior...	☐	☐	☐	☐	☐	☐	☐
((Comments)							

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	Dosage Instructions	Prescribed For

Continue to back side if needed

Please list any previous medications 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

Additional comments regarding sleep habits: _____

_____

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

Does he/she use any special/adaptive eating or drinking aids? ☐ 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: Street/PO Box: _____ City: _____ State: _____ Zip Code: _____

Primary Phone # ( ) _____ Fax # ( ) _____

APPLICATION SUBMISSION

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION

- ☐ Current photograph of applicant
- ☐ Psychological evaluation (preferable TEACCH evaluation) confirming diagnosis of Autism Spectrum Disorder
- ☐ Social History
- ☐ Medical History
- ☐ Educational History
- ☐ Individualized Support Plan (as warranted)
- ☐ Other information as appropriate (please list): _____

This Application for Services is being completed by: _____

Relationship to the applicant: _____

Current Mailing Address: Street or PO Box: _____
City: _____ State: _____ Zip Code: _____

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

Email Address: _____

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

Print Name: _____

Signature: _____ Date: _____

Application Submission Instructions

Once completed, the ***Application for Services*** along with all supporting documentation as requested can be submitted any of the following ways:

Fax to: (704) 982-8155

Email to: GHAAdmissions@ghainc.org

Mail to: GHA Autism Supports
Attention: Application for Services
PO Box 2487
Albemarle, NC 28002

Still Have Questions? Please contact the GHA Admissions and Referrals Line at **(704) 982-9600 ext. 200**

The ***Application for Services***, along with other information regarding the services provided by GHA Autism Supports, as well as links to valuable resources, can be found on our website at **www.ghaautismsupports.org.**

MISSION: GHA Autism Supports provides quality, community services to meet the unique needs of individuals with Autism Spectrum Disorder.

VISION: We will create environments where people of all ages with Autism Spectrum Disorder are understood, valued for their diversity and are given opportunities to grow, as well as contribute to the community.

VALUES: We value the uniqueness of each individual with Autism Spectrum Disorder and seek to incorporate their strengths, abilities, interests and choices in the planning and provision of services.