



**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)

<b>OFFICIAL USE ONLY</b> Application Received: _____ Approved for Services: _____
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## Application for Services

**PLEASE PRINT OR TYPE INFORMATION CLEARLY**

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

### IDENTIFYING INFORMATION

Individual's Name: \_\_\_\_\_  
First                      Middle                      Last                      Preferred

Gender: \_\_\_\_\_                      Date of Birth: \_\_\_\_\_

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      Confirmed diagnosis of Autism Spectrum Disorder?  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.....	<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

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

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

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

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

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

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

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

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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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							
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>							

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 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](mailto: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.ghautismsupports.org](http://www.ghautismsupports.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.