Administrative Office
P.O. Box 2487, Albemarle, NC 28002

Wilmington 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**
☐ **Morrow Valley Farmstead (medical needs facility)**

IDENTIFYING INFORMATION

Individual's Name: _____
First Middle Last Preferred

Gender: _____ **Date of Birth:** _____

Where does the individual currently reside? _____

Medicaid #: _____ **Medicaid County of Origin:** _____

If applicable, Medicare #: _____ **Prescription Drug Plan:** _____

If applicable, any additional third-party coverage: _____

Confirmed Diagnosis of autism spectrum disorder: ☐ **Yes** ☐ ***No**
*** must have confirmed diagnosis to be eligible for placement**

Confirmed Disability Approval: ☐ **Yes** ☐ ***No**
*** must be confirmed to be eligible for placement**

List all services currently receiving: _____
_____

Managed Care Organization (MCO) associated with? _____

List all previous services this individual has received:

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

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:** _____

SOCIAL/ FAMILY

Mother
Name: _____

Current Address: Street or PO Box: _____
City: _____ **State:** _____ **Zip Code:** _____
Email: _____
Primary Phone #: (_____) _____ **Alternate Phone #:** (_____) _____
Occupation: _____

Father
Name: _____
Current Address: Street or PO Box: _____
City: _____ **State:** _____ **Zip Code:** _____
Email: _____
Primary Phone #: (_____) _____ **Alternate Phone #:** (_____) _____
Occupation: _____

Siblings:

Name:	**Contact Number:**
_____	(____) _____
_____	(____) _____
_____	(____) _____
_____	(____) _____

Other Significant Persons:

Name	**Relationship**	**Contact Number**
_____	_____	(____) _____
_____	_____	(____) _____

DEVELOPMENTAL INFORMATION

Indicate the level of assistance needed:

Indicate whether or not an individual can	**Yes**	**No**	BLANK SPACE	-----	**Indicate by checkmark ✓ Select One** **Bathe/Shower**
Sort by size					None (can do on their own)
Sort by color					Minimal assistance (gestures or prompts)
Sort by function					Partial assistance
Correctly spell/write name					Complete Assistance
Count 10 or more objects				-----	**Brush Teeth**
Tell time (on the hour or on the half hour)					None (can do on their own)
Understand functional signs (exit, bathroom, etc.)					Minimal assistance (gestures or prompts)
Do simple addition & subtraction					Partial assistance
Read/comprehend simple sentences					Complete Assistance
Read/comprehend newspapers or magazines				-----	**Toileting**
Understanding meaning of "no"					None (can do on their own)
Understand one-step directions					Minimal assistance (gestures or prompts)
Understand multi-step directions					Partial assistance
Ask a simple question					Complete Assistance

Indicate whether or not an individual can	Yes	No	BLANK SPACE	-----	Indicate the level of assistance needed: Indicate by checkmark ✓ Select One **Dress self**
Relate experience when asked					None (can do on their own)
Tell a story, joke, or plot					Minimal assistance (gestures or prompts)
Describe realistic plans					Partial assistance
Identify currency (money)					Complete Assistance
Make simple purchases				-----	**Participate in household chores**
Make correct change					None (can do on their own)
Use checking/savings account					Minimal assistance (gestures or prompts)
Remain unsupervised for a period of time					Partial assistance
Understands 911					Complete Assistance
Can evacuate emergency situation without prompts				-----	**Basic meal preparation**
Makes request for things wanted or desired					None (can do on their own)
Make or provide comments					Minimal assistance (gestures or prompts)
Engage in social routines					Partial assistance
Seek information from others					Complete Assistance
Understands gestures				-----	**Feed self**
Understands signs					None (can do on their own)
Uses special system (e.g., pictures, objects, cards)					Minimal assistance (gestures or prompts)
Able to give information					Partial assistance
Able to reject or refuse things that are undesirable					Complete Assistance

Indicate by checkmark ✓

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							
Damages own or others' property							
Disrupts others' activities							
Bites self							
Scratches/pinches self							
Hits self							
Bangs head							
Bites others							
Scratches/pinches others							
Hits others							
Kicks others							
Runs or wanders away							
Steals							
Eats/mouths inedible items							
Displays sexually inappropriate behavior							
Additional Information or Comments on any of the above:							

Please note: GHA Autism Supports is a restraint-free organization, and we are unable to offer placement to individuals requiring the use of restrictive interventions.

MEDICAL INFORMATION

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

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

Medical Hospitalizations & Surgeries:

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

Psychiatric Hospitalizations/ Crisis Stabilization

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

Current Medications:

Medication Name:	Dosage Instructions:	Prescribed for:

Previous Medications:

Medication Name:	Dosage Instructions:	Prescribed for:

Indicate by checkmark ✓

☐ Independent---the individual is totally responsible for self-medication.

☐ Assistance---staff/others keep medication; the individual participates with assistance.

☐ Total Support---the individual is completely reliant on someone else to administer medications.

How does the individual indicate not feeling well? _____

_____

Medical information . . . continued

Indicate by checkmark ✓

✓	Hearing	✓	Vision	✓	Mobility
	Undetermined		Undetermined		Walks independently
	Normal		Normal		Walks independently, but with difficulty
	Mild loss (difficulty hearing normal speech)		Moderate impairment (trouble seeing distances, curbs, etc.)		Walks independently with corrective device
	Moderate loss (difficulty hearing loud speech)		Severe impairment (cannot see faces, line on which to write or mark)		Walks only with assistance from another person
	Severe loss (can only hear amplified speech)		Light perception (sees only light and/or shadows)		Does not walk
	Profound loss		Blind		

Additional comments regarding hearing, vision, or mobility? _____

Sleep Habits:

Typically sleeps: ☐ All night ☐ 3-5 hours a night ☐ Less than 3 hours a night

Uses: (check all that apply) ☐ Standard bed ☐ Adapted bed ☐ Bed rails

Additional sleep comments _____

Special Diet: ☐ No ☐ Yes Explain: _____

Special adaptive eating/drinking aids? ☐ No ☐ Yes Explain: _____

Choking or Swallowing concerns? ☐ No ☐ Yes Explain: _____

Require staff that are trained in special health care procedures: ☐ No ☐ Yes Explain: _____

Medical Diagnosis:

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

☐ No ☐ Yes Explain: _____

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

☐ No ☐ Yes Explain: _____

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

☐ No ☐ Yes Explain: _____

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

☐ No ☐ Yes Explain: _____

Urinary: (e.g., Kidney problems, etc.)

☐ No ☐ Yes Explain: _____

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

☐ No ☐ Yes Explain: _____

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

☐ No ☐ Yes Explain: _____

Seizures: (e.g., heart disease,

☐ No ☐ Yes Describe typical seizures: _____

Frequency: ☐ 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

Current Primary Care Physician: _____ Practice Name: _____

Address: _____City: _____ State: _____ Zip Code: _____

Primary Phone#: (___) _____ Fax: (___)_____

APPLICATION SUBMISSION

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION

- ☐ **Psychological evaluation confirming diagnosis of autism spectrum disorder**
- ☐ **Medical- last physical**
- ☐ **Individualized Support Plan (as warranted)**
- ☐ **Other information as appropriate (please list):** _____

This Application for Services is being completed by: _____
Relationship to the applicant (individual): _____
Current Mailing Address: Street or P.O. Box: _____
Primary Phone #: (____) _____ **Alternate Phone#: (___)** _____
Valid email address: _____

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

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: (980) 443-5089

Email to: GHAAdmissions@ghainc.org

Mail to: **GHA Autism Supports**
Attention: Application for Services
P.O. Box 2487 Albemarle NC 28002

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.