Administrative Office

Official Use Only

Application Received: ---------------------------------

Approved for Services: --------------------------------

P.O. Box 2487, Albemarle, NC 28002

Wilmington Office:

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

**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: Confirmed Disability Approval:

Yes Yes

**\*No**

* **must have confirmed diagnosis to be eligible for placement**

\*No

* **must be confirmed to be eligible for placement**

List all services currently receiving:

Managed Care Organization (MCO) associated with?

 Innovations Waiver: Yes No

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: Email:

State:

Zip Code:

Primary Phone #: ( \_) Occupation:

Alternate Phone #: ( )

Father

Name: Current Address: Street or PO Box:

City: Email:

State:

Zip Code:

Primary Phone #: ( ) Occupation: Siblings:Alternate Phone #: ( )

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** |  | **-----** | **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 |

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Indicate the level of assistance needed:



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicate whether or not an individual can** | **Yes** | **No** |  | **-----** | **Indicate by checkmark A picture containing kitchenware, tool  Description automatically generated** 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:

|  |  |
| --- | --- |
|  |  (Date) |
|  |  (Date) |
|  |  (Date) |

Psychiatric Hospitalizations/ Crisis Stabilization

|  |  |
| --- | --- |
|  |  (Date) |
|  |  (Date) |
|  |  (Date) |

Current Medications:

|  |  |  |
| --- | --- | --- |
| Medication Name: | Dosage Instructions: | Prescribed for: |
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Previous Medications:

|  |  |  |
| --- | --- | --- |
| Medication Name: | Dosage Instructions: | Prescribed for: |
|  |  |  |
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|  |  |  |

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 

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| A picture containing kitchenware, tool  Description automatically generated | **Hearing** | A picture containing kitchenware, tool  Description automatically generated | **Vision** | A picture containing kitchenware, tool  Description automatically generated | **Mobility** |
|  | Undetermined |  | Undetermined |  | Walks independently |
|  | Normal |  | Normal |  | Walks independently, but with difficulty |
|  | Mild loss (difficulty hearingnormal speech) |  | Moderate impairment (trouble seeingdistances, curbs, etc.) |  | Walks independently withcorrective 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 hearamplified 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: ( )

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION

**APPLICATION SUBMISSION**

# 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**](http://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.