Faith-based support and services for individuals with autism and intellectual disabilities

Mail Form to:
Support Center
1625 East Market Street
York, PA 17403
717-747-9000

PLEASE PRINT

Please list which program referral is for: ______________________

Individual's Name: ______________________

Address: ______________________

City: ____________ State: ______ Zip Code: ____________

Phone #: ____________ Social Security #: ____________

Gender: _____ Date of Birth: ____________ Race: ____________ Religion: ____________

Hair Color: ____________ Eye Color: ____________ Identifying Marks: ____________

Language/Means of Communication: ______________________

Family/Guardian: ______________________

Address: ______________________

City: ____________ State: ______ Zip Code: ____________ Home Phone #: ____________

Cell #: ____________ Work #: ____________ Email: ____________

Please list emergency contacts

Name: ____________ Phone #: ____________

Name: ____________ Phone #: ____________

Primary Physician: ____________ Phone #: ____________

Address: ______________________

City: ____________ State: ______ Zip Code: ____________

Hospital Preference: ______________________

Other Medical Providers: ______________________

Supports Coordinator: ____________ Phone #: ____________

List Type of Waiver: ______________________

Medical Issues

Diagnoses: ______________________

____

____

Level of disability: severe/moderate/mild (circle one)

Allergies: ______________________

____

Seizures (if yes, please describe): ______________________

____

Medical devices/adaptive equipment needed: ____

____

Any other medical conditions/concerns: ____

____

Please list medications: ____

____

Self-medicating? ____

Any special instructions for administering medications? ____

____

Any vision/hearing limitations? ____

Any sensory issues? ____

Behavioral Issues

If applicable, please describe any challenging behaviors: ____

____

____

Any antecedents or triggers for behaviors: ____

____

Frequency: ____

Best way to handle behavior issues: ____

____

____

Food/meals/eating

Level of assistance needed when eating: ____

____

Choking risk: ____

Any difficulty chewing or swallowing: ____

Any special food/drink preparation needed: ____

____

Any dietary restrictions: ____

____

Any adaptive devices used: ____

Daily Living Skills

(Please note – Independent, Verbal Prompts, Physical Prompts, or Total Assistance, as well as any adaptive equipment used)

Personal Care

Bathing: ____

Dressing: ____

Eating: ____

Taking medications: ____

Brushing teeth: ____

Toileting: ____

Ambulation: ____

Ability to care for personal belongings: ____

Housekeeping skills: ____

Safety Awareness

Street Safety: ____

Fire Safety: ____

Hot surfaces: ____

Hot water: ____

Poisons: ____

Strangers: ____

Sharps: ____

Emergency situations: ____

Can use 911: ____

Ingests non-edibles: ____

Ability to be left unsupervised and length of time: ____

____

Social Skills

Able to get along with others: ____

Able to follow directions: ____

Ability to communicate wants/needs: ____

Preference for independent or group activities: ____

General emotional state: ____

List strengths: ____

____

____

List needs: ____

____

____

List activities enjoyed: ____

____

____

List other important information to know: ____

____

____

List community activities or involvements (church, volunteering, clubs, Special Olympics, etc.): _______________________

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