BREAKTHROUGH
improving the lives of adults with autism

BACKGROUND INFORMATION

Name				**Birthdate**	
Gender		**Height**		**Weight**	
Race/Ethnicity		**Eye Color**		**Hair Color**	
Primary Language		**Blood Type**		**Marital Status**	
Current Address					
Medicaid Number		**State ID number**			
Conservator (Does the individual have a conservator/guardian? If so, who is that individual?)	Yes No				
Consent for Referral (Signature of Person or Conservator/Guardian)	As the applicant or conservator/guardian for the applicant, I give consent to the admission and care offered within the requested program. X				

PROGRAM INTEREST

Program(s) Requested (Circle each requested program)	**Residential** (24 hour daily support towards independent living)	**Supported Employment** (program devoted to finding competitive employment)	**Day Services** (Monday–Friday community based service from 9-3)
	Personal Assistance (daily supports in the current home)	**Respite/Recreation** (Saturday program offering recreation opportunities)	**Asperger's Support** (Monthly activity/support group for individuals with Asperger's diagnosis)

Contacts	**Name**	**Phone**	**E-mail**
Parent/Guardian/ Conservator			
Primary Care Physician			
Psychiatrist			
Neurologist			
Physician Specialty:_____			
ISC			
Behavior Analyst			
Therapist Specialty: _____			
Therapist Specialty: _____			

Reason for Referral (Describe current situation)		
Physical Health Diagnoses List any medical diagnoses or physical health problems (visual impairment, arthritis, paralysis, etc.)		
Describe current home situation Housemates? Level of Independence? Individuals within his/her circle that are important to him/her?		
Day Activities Describe the person's daily life routine.		
Medicaid Waiver Does the individual qualify for Medicaid Wavier services? If so, for which Medicaid waiver services has funding been applied or approved?	☐Statewide Waiver ☐Self-Determination Waiver	☐None ☐In Process of Approval ☐Approved

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MEDICAL INFORMATION	
Physical Health Diagnoses List any medical diagnoses or physical health problems (visual impairment, arthritis, paralysis, etc.)	
Communicate How does s/he communicate when s/he is hurting or injured?	
Medication List all medications, specific schedule, and purpose(s). Include prescribed, over the counter medications, and supplements.	
Can s/he give his/her own medications? How does s/he take medications? Does s/he know what medications are prescribed and for what purpose?	
Treatments List all current medical treatments, specific schedule, and for what purpose(s) (i.e. C-PAP machine, nebulizer, etc.)	
Sleep Pattern (Describe sleep in terms of a 24-hour day)	
Weight Have there been changes in weight over the past year? (Describe)	
Medication/ Food Allergies Does the person have allergies to food or medications? If so, list the food or medication and the reaction.	

Is the person on a special diet? (Regular, Diced, or Pureed)	
Current Assistive Devices (wheelchair, walker, etc.)	
PSYCHIATRIC INFORMATION	
Current Mental Health Diagnoses (Clinical and Personality Disorders)	
Intellectual Disability Diagnosis (Include dates of assessment, IQ, and Adaptive Scores)	
History of Inpatient Psychiatric Treatment (Include admission date, reason, length of stay, and outcome)	
BEHAVIOR INFORMATION	
Employment Does s/he have a job or want to pursue future employment?	
Evacuation Can the individual self-evacuate in case of emergency? What supports are needed?	
Self-Care Describe self-care abilities. (showering, toileting, dressing, laundry, etc.)	

Chores Describe household maintenance abilities. (dishes, vacuuming, cleaning bathroom, etc.)	
Food Preparation Describe food preparation abilities. (cutting, microwave use, etc.)	
Fears/Concerns Is s/he afraid of anything? Does s/he not want to be around certain people or things?	
Safety Are there concerns about his/her safety awareness?	
Transportation Does s/he drive, use public transportation?	
Sensory Does s/he have any sensory integration issues? Does s/he have sensory preferences/activities?	
Routines Does s/he engage in any routine/ritualistic behaviors? If so, describe.	
Recreation/Leisure What does s/he like to do for fun? What are his/her hobbies and interests? What activities does s/he enjoy but have limited access?	
Law Enforcement Is there a history of law enforcement involvement or legal charges? If so describe.	

Maladaptive Behaviors	Behavior	Description/Intensity/Duration
	Physical Aggression (hitting, spitting, kicking, etc.)	
	Self-Injury (head-banging, picking, etc.)	
	Property Destruction (punching walls, breaking items, etc.)	
	Elopement (running away from home or family, etc.)	
	Sexually Inappropriate Behavior (inappropriate touching, etc.)	

FINANCIAL INFORMATION

Income What is his/her monthly income, including any supplemental benefits?	
Money How is his/her money managed currently?	
Representative Payee Will Breakthrough be asked to become rep payee?	

DOCUMENT ATTACHMENTS (all referrals)

Please provide the following documents for review with this application.	
Most recent annual Physical	
Current list of medical providers, with phone numbers and addresses	
Historical clinical assessments (medical, psychiatric, behavior, therapies)	
ISP/IEP (Most recent IEP if out of school)	
Behavior Support Plan, Most Recent CSMR or Follow Up Note.	
Proof of income (pay stubs, SSI award letter, food stamps, bank statement, etc.)	
Proof of insurance	
If we chose to admit this individual, we will need the original or a copy of the following documents.	
Social Security Card	Certified copy of Birth Certificate
State ID	Community Development Block Grant Income Form
Current Photo	