URBAN AUTISM SOLUTIONS

JULIE+ MICHAEL TRACY FAMILY FOUNDATION

The information asked below allows us to get a better understanding of your needs and goals. However, we understand that you may not feel comfortable answering some of these questions at this point. For that reason, questions with an asterisk (*) are optional at this time.

Name: _____ Age:_____ Date:_____

Name of Parent(s)/Guardian(s): _____

Address:_____

Email: _____ Phone:_____

Date of Birth: _____ Gender: _____

Name of School (current or last year completed) _____

Year: _____

Information given by: _____

Relationship to applicant: _____

Please take just a moment to answer some questions about yourself or the family member for whom you are interested in seeking services, so that we might begin to get to know you better.

Health

Diagnoses:_____

Current Medications:* _____

Past Medical Concerns:* _____

Medication Administration: (self, prompted, needs oversight, cannot manage without support, etc.)

_____

_____

Communication

Is Verbally fluent: _____Uses Short Phrases: _____
Uses Augmented Communication Devices: _____
Does not have a Reliable Method of Communicating with Others_____
Does the applicant use smart phone technology?_____
Please describe. Does the applicant answer the phone consistently?_____
Social Media Use? _____ Hours Per Day: _____
Are electronics problematic for your child? _____

Independent Living Skills

	Independent	Requires Some Assistance	Dependent on Assistance
Personal Care			
Cooking			
Cleaning			
Laundry			
Shopping			
Transportation			
Finances			
Medical Decisions			

Personal Care Detail

	Independent	Requires Some Assistance	Dependent on Assistance
Dressing			
Bathing/Showering			
Toileting			
Shaving			

Can the applicant be left out of the line of sight for 3-4 hours at a time? _____
Does your family member have any experience living away from you? _____
What best describes the sleeping habits of the applicant?
_____
Are there any unusual toileting concerns or bathroom habits?_____

Please describe the applicant's sexual history._____

Does this applicant see a therapist? Is there a need for ongoing counseling?_____
_____

Behavioral Issues History

Please respond as accurately as possible. An indication of "yes" will not disqualify you from further services, but will help us to better understand your needs.

_____	Physical Aggression	_____	Verbal Aggression
_____	Self Injurious Behaviors	_____	Property Abuse
_____	Elopement/Leaving Area	_____	Sexual Abuse
_____	Fire starting	_____	Other (Describe)

Mobility

_____ Navigates Independently on Community Streets
_____ Able to safely use Public Transit (with practice/Smart Phone)
_____ Navigates Independently within known public buildings
_____ Navigates Independently within home
_____ Needs close supervision at all times during waking hours

What does the ideal day look like for you or your family member for whom you are interested in obtaining services? Please tell us how a preferred schedule might look, if all conditions were ideal. Include any work, volunteer, leisure and rest time.

What have you tried so far? What works best?

What type of assistance or service are you seeking today or in the near future?

Residential_____ Vocational Opportunities_____
Social Outings/Activities_____ Help Creating a Meaningful Day_____

How did you hear about Urban Autism Solutions?
Hospital_____ Web Search_____ Other_____
Doctor_____ Friend_____

Please feel free to add any information that you would like us to know as we become acquainted.

Please return completed form and $175 application fee to:

Urban Autism Solutions
1212 West Flournoy Street
Chicago, IL 60607
info@jmtf.org