CREATE SERVICE
APPLICATION WORKSHEET

FORM COMPLETED BY _____ DATE OF APPLICATION_____

CHILD INFORMATION

LAST NAME _____ FIRST NAME ____ _____

DATE OF BIRTH _____/_____/_____ AGE _____ SOCIAL SECURITY # _____-_____-_____

MOTHER'S NAME _ _____ FATHER'S NAME _____

GUARDIAN'S NAME _____ RELATIONSHIP ___ _____

ADDRESS _____ZIP _____

HOME PHONE # ( ) _____ WORK PHONE # ( ) _____

NAME OF MEDICATION	DOSAGE	SCHEDULE

PRESCRIBER _____ PHONE # _____

SCHOOL INFORMATION

SCHOOL DISTRICT _____ SCHOOL _____

GRADE LEVEL _____ SPECIAL EDUCATION: Y OR N

INSURANCE INFORMATION

COMMERCIAL INSURANCE _____ Y OR N

NAME OF PROVIDER _____

MA RECIPIENT # (10 DIGIT) _____ CBH Y OR N

EVS DATE: _____

MENTAL HEALTH SERVICES RECEIVED

CURRENT MENTAL HEALTH SERVICES RECEIVED: _____
AGENCY NAME: _____
LEAD CLINICIAN NAME: _____
LEAD CLINICIAN CONTACT INFO: PHONE: _____
EMAIL: _____

SELF-TOILETING ABILITY: YES OR NO

SELF-FEEDING ABILITY: YES OR NO

DSM V Diagnosis: _____ _____
_____
_____
_____
_____

SOURCE OF AUTISM DIAGNOSIS:

- ☐ Psychological/Psychiatric Evaluation
- ☐ Developmental Pediatrician
- ☐ School/Educational Evaluation (consider referring to EAS)
- ☐ Other: _____

DATE OF MOST RECENT EVALUATION: _____

COPY OF DOCUMENTATION EVALUATION: The parent/guardian reported the report will be provided as follows:

___ Emailed or faxed prior to the intake

___ Brought to the intake

___ Release of information needed at intake to request copy of evaluation from external provider

COMMUNICATION METHODS (Check those that apply)_____

- ❑ Verbal
- ❑ Picture Exchange Communication System (PECS)
- ❑ Sign Language
- ❑ Extremely limited speech
- ❑ Completely non-verbal
- ❑ Additional Information: _ _____

SENSORY ISSUES (Check those that apply)

- ❑ Loud Sounds
- ❑ Lighting (Too bright and/or dark)
- ❑ Water
- ❑ Temperature (Too hot and/or cold)

- ❑ Art Materials (e.g., paints, etc.) _____ _____
- ❑ Other (Please specify): _____
- ❑ Large Groups

BEHAVIORAL ISSUES (Check those that apply)

- ❑ Bangs head
- ❑ Bites hand
- ❑ Pinches Self
- ❑ Scratches Self
- ❑ Hits Others
- ❑ Elopes/Runs Away
- ❑ Bites Others
- ❑ Pinches Others
- ❑ Scratches Others
- ❑ Verbally Instigates Others
- ❑ Additional Information:

MEDICAL ISSUES (Check those that apply)

- ☐ Seizure Activity
- ☐ Hearing Aid(s)
- ☐ Eye Glasses
- ☐ Protective Headgear
- ☐ Allergies (Please Specify): _____
- ☐ Other (Please Specify):_____

CREATE Client Exclusions

Please check off indicating any exclusionary criteria.

1. **Clients who do not have a current, active Autism Spectrum Disorder** [ ]
2. **Aggressive Behaviors (behaviors that occurred within the last 6 months.)** [ ]
   - Aggression that causes injury to others, animals, or self [ ]
     Examples: Biting, broken bones, open wounds, etc.
   - Use of or possession of weapons. [ ]
     Examples: Bringing a knife to school within the last 6 months
   - Homicidal behaviors [ ]
   - Daily incidents of aggression [ ]
     Example: Attempting to physically hurt someone at least once per day
3. **Clients that have been placed in a higher level of care.**
   - Client in RTF in last 4 months [ ]
   - Client in partial hospitalization in last 3 months [ ]
   - Client in inpatient in last 3 months [ ]
4. **Inappropriate sexual behaviors within the last year** [ ]
   - Masturbation in public [ ]
   - Intentional inappropriate touching of peers [ ]
5. **Fire setting within the past year** [ ]
6. **Clients involved with JPO** [ ]
7. **Active drug or alcohol use/abuse** [ ]
8. **Client is unable to independently use the bathroom** [ ]
9. **Client has no formal means of communication** [ ]
10. **Client is unable to self feed** [ ]
11. **Elopement that puts the child in danger or prevents them from participating in group activities in the last month** [ ]
12. **Client has not yet attended kindergarten** [ ]
13. **Client requires one on one support to participate in the service** [ ]

Other comments or concerns:

_____

_____

Please sign below:

X_____ _____ _____ Date:_____

Signature Name Printed Relationship to child