

**SVH Services
Intake and
Application**

1009 1st Street SW
Roanoke, VA
24016

p-540-904-2957
f-540-904-2958



Office use:
Date Rec'd? _____
Payment? _____

Name: _____ Birthdate: _____

Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Guardian(s) Name:

(1) _____ Day Phone: _____ Evening Phone: _____

Email address: _____ Cell Phone: _____

(2) _____ Day Phone: _____ Evening Phone: _____

Email address: _____ Cell Phone: _____

Emergency Contact: (Other than guardian):

(1) _____ Relationship to you _____ Day Phone: _____ Evening Phone: _____

Cell Phone: _____

(2) _____ Relationship to you _____ Day Phone: _____ Evening Phone: _____

Cell Phone: _____

I am interested in the following SVH Programs: Circle location- **Roanoke** **Lynchburg** **Lexington**

_____ In-Home Program (Child and Adult- up to age 22-EPSDT, private pay or insurance)

_____ Blue Ridge Autism and Achievement Center (school year)-

_____ 1:1 year round ABA Program _____ STARS _____ Tutoring _____ Assessments _____ Consultation

_____ BRAAC Summer PLUS Programs- _____ 1:1 ABA Program _____ STARS _____ Camp AuSome

_____ Achieve Employment Services (Adult)

_____ Katie's Place Community Day Program/ Community Engagement (Adult)

_____ Therapeutic Consultation (Child and Adult)

_____ Daily Living Skills (cooking, laundry, cleaning, shopping, etc.) (Child and Adult)

_____ Supportive In-Home/Independent Living Supports

I affirm that all information on this application is true and correct. I understand that all requests for services for St. Vincent's Home are subject to approval by the Executive Director and designated personnel. I understand if the application is initially approved, a visit will be scheduled soon. All information collected will be used for admission consideration and is confidential. I also give permission for SVH to review any of my records.

Signature of Applicant/Guardian

Date

St. Vincent's Home provides access to programs, employment, or other SVH activities without regard to age, race, color, national or ethnic origin, gender, religion or disability.

CONFIDENTIAL

Name: _____ Birthdate: _____

Medical History:

Please list all diagnoses and who diagnosed. (Please attach additional sheet if necessary.)

Diagnosis: _____ Diagnosis received by: _____ Date: _____

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Please list any medications person is currently taking. (Please attach additional sheet if necessary.)

Medication: _____ Daily Dosage: _____

Reason for taking: _____

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Reason for taking: _____

Please list any allergies: (Attach additional sheet if necessary.)

Environmental _____

Food _____

Medication _____

Are you medically stable? ____ Yes ____ No

If no, please explain: _____

Do you now, have or have you ever, had seizure activity? ____ Yes ____ No

If yes, please explain: _____

Is your vision within normal limits? ____ Yes ____ No

If no, please explain: _____

Do you have any unusual responses to visual stimuli? ____ Yes ____ No

If yes, please explain: _____

Is your hearing within normal limits? ____ Yes ____ No

If no, please explain: _____

Do you have any unusual response to auditory stimuli? ____ Yes ____ No

If yes, please explain: _____

Have you been diagnosed with an auditory processing disorder? ____ Yes ____ No

If yes, please explain: _____

Do you have any unusual responses to touch or other tactile stimuli? ____ Yes ____ No

If yes, please explain: _____

CONFIDENTIAL

Name: _____ Birthdate: _____

Educational History: Please list previous schools, therapy programs, home programming and treatments. Attach additional sheets if necessary. Please attach any treatment plans- IEP, IIP, ISP and psychological reports.

Name of schools, programs, or independent consultants:

Types of therapies received, both public school or privately, and agency that provided therapies: (Speech, OT, PT, etc)

Types of teaching models/discipline, used: (Discrete trial, verbal behavior, Orton-Gillingham, etc.)

Current Functional Skills:

Please check the following skills the person IS ABLE do independently:

- shower/bathe dress tie shoes operate a microwave cook a meal drive a car button
- launder clothes operate a phone/text operate a dishwasher make a bed brush teeth wash hands
- exchange money balance a check book navigate the internet make a medical appointment toilet
- take turns with others use zippers eat with utensils throw a ball communicate needs uses toys appropriately

Lack of ability to perform the above activities does not keep you from participating in SVH programs. It help us to decide which programs might be appropriate. SVH also consults with DARS, case managers, and reviews records, assessments, etc. Please list any other feedback here:

BRAAC Autism Program questions:

Are diapers or pull-ups in use? _____ When? all times only at night

What modes of communication are used? none vocal ASL adapted sign PECS

Assistive Technology (e.g. Dynavox, Proloquou, etc.) Please list: _____

List things that are reinforcing (e.g. praise, electronics, music, bubbles, food) _____

CONFIDENTIAL

Name: _____ Birthdate: _____

Please indicate below any problem behavior demonstrated, both minor and those of great concern.
Attach additional sheets if necessary.

Aggression towards others? Please explain by describing situations likely to trigger and type of aggression (hitting, biting, etc.):

Aggression towards self? Please explain by describing situations likely to trigger and type of aggression (hitting, biting, etc.):

Highly disruptive behavior? Please explain Please explain by describing situations likely to trigger and type of behavior (screaming, cursing, etc.)

Have you ever been dismissed from another Employment Services Organization, school, day care, in-home program, etc.?

Primary Insurance Provider: _____

Secondary Insurance/Medicaid: _____

Do you currently receive any form of Medicaid Waiver services? _____ Yes _____ No

If yes, please list type of waiver and name and contact information of Case Manager:

Please list your Medicaid number: _____

Do you have a DARS Counselor? _____ Yes _____ No

If yes, please share name and contact information

Are you in school? _____ Yes _____ No

If yes, please provide name of the school/ school district.

If submitting an application for Blue Ridge Autism and Achievement Center programs, be sure to include a \$50 application fee made out to BRAAC.