SVH Services Intake and Application

416 Campbell Ave., SW, Suite 103
Roanoke, VA 24016

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

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

Name: _____ Birthdate:_____ Grade ____ 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

_____ Preschool peer model (3 years old to 5 years old)

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.

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: _____

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, Proloqou, 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.