https://aspergerworks.org
cs@aspergerworks.org
48 Marshland Street
Haverhill, MA 01830

Person Making Referral

Contact Person:

_____

First Name Last Name (Agency)

Is the person needing assistance same as applicant? ☐ YES ☐ NO

If no, contact's home phone number _____ mobile phone

Are there any special instructions for contacting client? ☐ YES ☐ NO

If yes, please elaborate here:

_____

How did you hear about Asperger Works?

_____

Client Information

_____

First Name Middle Initial Last Name

Date of Birth: _____

Phone/Mobile Number: _____

Address:

_____

Street Address Apt. # / Floor / Suite #

_____

City State Zip Code

Any disability beside Asperger's Syndrome? ☐ YES ☐ NO

If yes, please provide more information here:

_____

Preferred Language: _____

Reason for Contact

Need Assistance With _____

Reference Date: _____

01/12/2023

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CLIENT PROFILE INTAKE

DATE OF INTAKE: _____ STAFF NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

STREET ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

HOME PHONE: _____ MOBILE: _____ OTHER: _____

BIRTH DATE: _____ GENDER: ☐ Male ☐ Female VETERAN ☐ Yes ☐ No

SOC. SEC. NO. _____ SPECIAL CONSIDERATION: _____

E-MAIL: _____ _____

(Specify special consideration for communication)

ETHNICITY

☐ African American
☐ Asian
☐ Hispanic/Latino
☐ Native American/Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ White/Caucasian
☐ Other _____
☐ Not given

LAGUAGE FOR WRITTEN MATERIAL

☐ English ☐ Spanish ☐ Both ☐ Other _____

CLIENT ELIGIBILITY VERIFICATION

Significant Disability/Sensory Impairment have been verified: ☐ Yes ☐ No

Functional limitation(s) to independence has been verified: ☐ Yes ☐ No

There is adequate indication that the client will benefit from participation in services ☐ Yes ☐ No

How client eligibility was determined: (Check all that apply)

☐ OBSERVATION _____

☐ SELF-DISCLOSURE _____

☐ SSI/DI STUB/MASS HEALTH _____

☐ OTHER _____

☐ Client is eligible for services: _____ _____

STAFF SIGNATURE DATE

☐ Client is NOT eligible for services

DISABILITY

PRI	ALL		PRI	ALL	
☐	☐	ALS	☐	☐	Heart Disease
☐	☐	Amputation	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Late Deafness
☐	☐	Autism/Asperger's Syndrome	☐	☐	LD/ADD/ADHD
☐	☐	Blindness	☐	☐	Lupus
☐	☐	C.P.	☐	☐	M.D.
☐	☐	Cancer	☐	☐	M.R/Developmental
☐	☐	Chemical Dependency	☐	☐	M.S.
☐	☐	Chronic Fatigue Syndrome	☐	☐	Oral Deafness
☐	☐	COPD	☐	☐	Orthopedic
☐	☐	Deaf	☐	☐	Other - Cognitive
☐	☐	Degenerative Disease	☐	☐	Other - Neurological
☐	☐	Diabetes	☐	☐	Other - Physical
☐	☐	Down Syndrome	☐	☐	Other - Sensory
☐	☐	Dyscalculia	☐	☐	Parkinson's Disease
☐	☐	Dysgraphia	☐	☐	Polio
☐	☐	Dyslexia	☐	☐	SCI
☐	☐	Environmental Sensitivity	☐	☐	Speech Impairment
☐	☐	Epilepsy	☐	☐	Spina Bifida
☐	☐	Fibromyalgia	☐	☐	Stroke
☐	☐	Friedrich's Ataxia	☐	☐	TBI – Cognitive
☐	☐	Hard of Hearing	☐	☐	Visual Impairment

Other not listed above _____

Date of onset of primary disability _____

REASON FOR SEEKING SERVICES

Please check all that apply

CA	☐	Communication Assist.	EM	☐	Employment	SH	☐	Self-help/Personal Growth
CL	☐	Consumer/Legal Rights	ME	☐	Employment Maintenance	OT	☐	Other
ET	☐	Education/Training						

SPECIFIC SITUATION OR NEED: (Detailed reason for seeking services)

_____

_____

_____

_____

_____

EDUCATION

- ☐ 6th Grade and below
- ☐ 9th Grade
- ☐ 11th Grade
- ☐ High School
- ☐ Special Education
- ☐ Some College
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Trade School
- ☐ Graduate School

EMPLOYMENT

☐ EMPLOYED If yes, please give information below:

_____
_____
_____
_____
_____
_____
_____
_____
_____

INCOME

Source	Amount	Frequency (Weekly, Bi-weekly, Monthly, Annual
☐ SSDI		
☐ SS Retirement		
☐ SSI		
☐ Unemployment Compensation		
☐ EAEDC		
☐ Employment		
☐ Other		

NON-CASH BENEFITS

Source	Amount	Frequency (Weekly, Bi-weekly, Monthly, Annual
☐ Food Stamps		
☐ Fuel Assistance		
☐ Other		

COMMUNICATION AIDS/METHODS

- ☐ Communication Board
- ☐ TTY/TDD/Telebrailler
- ☐ Hearing Aids
- ☐ Assistive Listening Device
- ☐ Interpreter
- ☐ Computer-Assisted Communication
- ☐ Hearing Dog

TRANSPORTATION

- ☐ Own Transportation – Driver
- ☐ Own Transportation – Drives self
- ☐ Para-transit
- ☐ Public Transportation w/o Assistance
- ☐ Public Transportation with Assistance
- ☐ Drive by others, their vehicles

EMERGENCY CONTACT

In case of emergency, contact _____
First Name Middle Initial Last Name

_____
Street Address City State Zip Code

_____
Phone Mobile

_____
Relationship

PHYSICIAN

Primary Physician: _____
First Name Middle Initial Last Name

_____
Street Address City State Zip Code

_____
Phone TTY/TDD

Other: _____
First Name Middle Initial Last Name

_____
Street Address City State Zip Code

_____
Phone TTY/TDD

OTHER COMMENTS

_____

_____

_____

_____

_____

_____

OTHER ASSOCIATED PEOPLE

NAME: _____

ADDRESS: _____

PHONE/MOBILE: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

PHONE/MOBILE: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

PHONE/MOBILE: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

PHONE/MOBILE: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

PHONE/MOBILE: _____

RELATIONSHIP: _____

Asperger Works
Putting autism to work

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____

Address:

_____
Street Address

_____
City State Zip Code

I hereby authorize Asperger Works, Inc. (AWorks) to release and receive my individually identifiable medical or personal information for the strict purpose of assisting me in the achievement of the Goals as stated in my Asperger Works Service Plan (AWSP), or as authorized in other written or verbal documented communication with Asperger Works, Inc. staff members.

Client or Legal Guardian Signature: _____

Date: _____

☐ I authorize AWorks to release my information to any individual or agency as appropriate.

This release of information is valid for the duration of my time as an active client with Asperger Works, Inc. unless otherwise voided by a written request.

If you wish to have AWorks share information ONLY with a specific individual or agency, please check the appropriate box below:

☐ Social Security Administration
☐ MCDHH
☐ NILP
☐ Hospital Staff
☐ Home Health Care Agency
☐ PCA
☐ MRC
☐ DMH
☐ Health Insurance Provider
☐ Medical Professional
☐ Individual _____
☐ Other _____

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Visit us on the Web at **https://aspergerworks.org**

CONTINUE