Dear Service Provider:

The demands of caring for an individual with autism are great, and families frequently experience high levels of stress. Often, the lack of appropriate services adds to the frustration of families. To increase the awareness of currently available resources, the Kentucky Autism Training Center is gathering information about services to create an Autism Supports and Services Directory.

If you would like to share information with families about your organization, please complete the enclosed questionnaire and return to the Kentucky Autism Training Center. The directory will be made available to families and be posted on the Kentucky Autism Training Center’s website. Please feel free to share this information with families and professionals interested in enhancing services for individuals with autism spectrum disorders.

Sincerely,

Debbie Lorence, LCSW

Kentucky Autism Training Center
College of Education and Human Development
Dean’s Office
University of Louisville
Louisville, Kentucky 40292

Telephone: 502.852.7811 or 800.334.8635 ext. 852-7811
Fax: 502.852.7148
E-mail: debbie.lorence@louisville.edu
Web site: http://louisville.edu/education/kyautismtraining
AUTISM SUPPORTS AND SERVICES DIRECTORY

The information gathered from this questionnaire will be shared with families in the form of a directory that will be available on the Kentucky Autism Training Center’s web-site located at www.kyautism.com. Please complete both pages.

AGENCY/PROVIDER NAME

ADDRESS

ADDRESS 2

CITY STATE ZIP

TELEPHONE FAX

E-MAIL WEB-SITE

AGENCY CONTACT (for Services for Individuals with autism and/or family members)

CONTACT

TELEPHONE

E-MAIL

Does your organization have a waiting list? □ yes □ no If so, how long? _______________

What percentage of your clients are individuals with autism or their families? ________ %

PAYMENT ACCEPTED:

□ Impact  □ First Steps  □ Home and Community-based Waiver
□ Impact Plus □ Medicaid  □ Supports for Community Living Waiver
□ Passport  □ Private Insurance  □ Other (please specify below)

SERVICES ADDRESS NEEDS OF INDIVIDUALS AGED:  □ 0-3  □ 4-12  □ 13-18  □ Adults

NON-PROFIT ORGANIZATION: □ yes □ no
LIST COUNTIES SERVED:


PLEASE CHECK BOX NEXT TO SERVICES OFFERED BY YOUR ORGANIZATION.

☐ Adult Health Day Care ☐ Family Services ☐ Prevocational Services
☐ Art Therapy ☐ Group Services ☐ Primary Care
☐ Assessment and Reassessment ☐ Hippo Therapy/Therapeutic Horse ☐ Psychiatric Services
☐ Assistive Technology ☐ Back Riding ☐ Psychological Services
☐ Attendant Care ☐ Homemaker Services ☐ Recreational/Leisure Activity
☐ Audiology ☐ Individual Services ☐ Residential Crisis Stabilization Services
☐ Behavioral Health Evaluation ☐ Individual Therapy ☐ Residential Supports
☐ Behavioral Supports ☐ Intensive Level Evaluator ☐ Respite
☐ Care Management ☐ Intensive Outpatient Services ☐ Respite (Emergency)
☐ Collateral Services ☐ Learning Assessments ☐ Service Coordination
☐ Community Habilitation ☐ Legal Services ☐ Social Skills Group
☐ Community Living Supports ☐ Medication Management ☐ Specialized Medical Equipment and Supplies
☐ Day Care ☐ Minor Home Adaptations ☐ Speech Therapy
☐ Day Treatment ☐ Music Therapy ☐ Support Coordination
☐ Deal/Hard of Hearing ☐ Nursing ☐ Supported Employment
☐ Dental ☐ Occupational Therapy ☐ Therapeutic After School Program
☐ Developmental Evaluator ☐ Optometry ☐ Therapeutic Child Support Services
☐ Developmental Intervention ☐ Parent to Parent ☐ Therapeutic Foster Care Services
☐ Developmental Pediatrician ☐ Partial Hospitalization ☐ Therapeutic Group Residential Services
☐ Diagnostic Services ☐ Personal Care Services ☐ Therapeutic Summer Program
☐ Dietary Consultation ☐ Physician Specify: ☐ Training
☐ Educational Consultation ☐ Physical Therapy ☐ Tutoring
☐ Expressive Therapy ☐ Physician Specify:

Other (please specify below):


PLEASE RETURN COMPLETED FORMS TO:

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