Illinois Center for Autism

Adult Services
Request for Services
Pre-Screening Referral Form

Name: _____ **Date:** _____

Address: Street: _____ **City:** _____
State: _____ **Zip Code:** _____
Date of Birth: _____ **Age:** _____

Diagnosis/Disability: _____
Was diagnosis prior to the age of 22? _____ **Yes** _____ **No**
Social Security Number: _____ _____ _____

Type of services requested from ICA:
Assessment: _____ **Pasta Fare:** _____ **Off-site Employment:** _____

Did individual requesting services complete a school program? _____ **Yes**
_____**No**
LEA: _____
Date of completion/graduation: _____

Is the individual currently receiving other services or did in the past? _____ **Yes** _____ **No**
Agency: _____
Date(s) attended: _____
Reason for leaving: _____
_____

Is the individual registered for PUNS? _____ **Yes** _____ **No**
Is the individual Medicaid Waiver eligible? _____ **Yes** _____ **No**
Medicaid Number: _____
Does the individual receive:
Home Base Support Services funding? _____ **Yes** _____**No**
State of Illinois or Federal Funding? _____ **Yes** _____ **No**

Is Individual own guardian? _____**Yes** _____ **No**
If No, Guardian Name: _____ **email:** _____

Waiting list requisition made by/Relationship: _____

Phone: _____**Alternate Phone:** _____

Placed on vocational services waiting list: _____ **Yes** _____ **No**
If no, why? _____
_____
ICA staff member completing request for services: _____