MyGOAL

Gateway to Hope... Connections... Resources

Grant Application Medical Health Assessment

Questionnaire To be completed by a Health Care Professional (MD/DO/APN/PA)

This medical health questionnaire is used to determine the applicant eligibility, medical information must be provided for the applicant in order to be considered for the grant. It is essential for the grant committee to have the current health information, in order to be able to assess the degree of severity of the individual's health condition as a criteria for eligibility. This form should be completed by the applicant's physician and should be uploaded with the application for the MyGOAL autism grant.

Patient's Last Name: _____ Patient's First Name: _____

DOB: _____ Gender: _____ Age of Initial Diagnosis: _____

To Be Completed by a Health Care Professional:

Please provide information regarding the severity of the patient's Autism diagnosis:

Overall Developmental Level	☐ Development similar to neurotypical same age of peer	☐ Delays in development in 1 to 2 domains	☐ Delay in Development in 3 to 4 domains	☐ Significant developmental delay (≥5 domains)
Additional Comments				

Social Communication	☐ • Able to initiate interaction • Typical response to social overtures of others • Maintains interest during interaction • Minimal challenges relating emotionally	☐ • Difficulty initiating interaction • Atypical response to social overtures of others • Appear to have decreased interest in interaction • Challenges relating emotionally	☐ • Limited initiation of social interactions • Minimal or delayed responses to social overtures • Deficit in verbal and nonverbal social communication skills • Significant challenges relating emotionally	☐ • Severe deficit in verbal and nonverbal social communication skills cause severe impairments in functioning • Limited social interaction
Additional Comments				

Behavior	☐ • Minimal/no difficulty switching between activities • Flexibility of behavior; minimal interference with functioning in one or more contexts	☐ • Some difficulty switching between activities • Inflexibility of behavior causes significant interference with functioning in one or more contexts	☐ • Distress and/or difficulty changing focus or action • Restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer	☐ • Great distress/ difficulty changing focus or action • Restricted/repetitive behaviors markedly interfere with functioning in all spheres
Additional Comments				

Level of Support Required for Daily Living Skills and Education	☐ Independent with activities	☐ Able to complete activities with some support	☐ High level of disability but not completely dependent	☐ Completely dependent for all activities
Additional Comments				

Communication	☐ • Capable of complex sentences • Use of body language and gestures in addition to language • Understands time sequence • Engages in conversation	☐ • Sentences with 4 to 5 words • Answer simple questions • Understand key phrases • Understands 'who' 'what' 'when' 'where' 'why' questions	☐ • Answer simple questions non-verbally • Communicates with actions and gestures	☐ • Non-verbal • Limited to no communication/response in any form
Additional Comments				

Describe other health conditions that patient has (i.e., seizure, asthma, etc.): _____
_____

Special Considerations/Precautions: _____
_____

Health Professional Name: _____ Signature: _____

Name of Practice: _____ Date: _____

Address: _____ City_____ State _____ Zipcode _____

Phone Number : _____ Email: _____