Community TIES

Initial Information Form

This form will take between 30 minutes to an hour to complete. You may skip over any information you do not know, but please try to complete as much as necessary.

Section 1

Date		
Consumer's Name		
Address		
Telephone #		
Date of Birth		
Legal Guardian	Self? (circle) Y ☐ N ☐	Name of Guardian

Section 2

Name of Person Making Referral	
Agency/Relationship	
Telephone #	
E-Mail	
Parent / Guardian	
Telephone #	
E-Mail	

Section 3 (Please skip to Section 4 if you are not referring a child)

Is the child currently receiving, or will be receiving, intensive autism therapy in the next 12 months?	Yes ☐	No ☐
Does the child have a SED diagnosis?	Yes ☐	No ☐
Is the child on the CLTS waiver?	Yes ☐	No ☐

Section 4 – required for state reporting purposes

Gender		
Male ☐	Female ☐	Other/Unspecified/Non-Binary ☐

Ethnicity				
American Indian ☐	Asian or Pacific Islander ☐	Black ☐	Hispanic ☐	White ☐

Section 5

Has the person been found eligible for Long Term Support Services for a Developmental Disability?			
Yes ☐	by (Name of Person and/or Agency)		Don't Know ☐
Social Security Number			
M.A. Number			
ACS or MCI Number			
Funding Eligibility			
CLTS ☐	IRIS ☐	Family Care MCO ☐	Other ☐
Name of Long Term Support Management Agency (IRIS, MCO, or Child Case Management Agency)			
If IRIS, who is the FEA?			
Agency Contact Person			
Telephone #			
E-Mail			

Section 6

Where does this person reside?		
Parents home ☐	Apartment on own ☐	Apartment with roommate ☐
Foster Home ☐	Adult Family Home ☐	Other ☐
Caregiver with whom the consumer resides (Agency and contact person)		
Telephone #		
E-Mail		
School and/or Vocational Agency (Agency and contact person)		
Telephone #		
E-Mail		

Section 7

I. Professional Support/Agencies involved with consumer:

List any other agencies/programs or individual care givers that are providing services for the consumer. Include telephone numbers, e-mail and any particular comments.

II. Social/Emotional Support to Consumer/Family:

Describe relationship with others. Who is seen as a support to the consumer/family in times of need? May be friends, other family members, neighbors, teachers, co-workers, etc.

III. Behavior Challenge(s):

Describe behavior(s) including onset, where it occurs and how often. Include any concerns about how these behaviors could affect his/her future.

IV. Stress Triggers:

List any stress factors or indications that frequently occur prior to the behavior. May include activities, changes in schedule, time of day, etc.

V. Interventions:

What attempts have been made to support the behaviors, by whom, and what were the results?

VI. General Health:

Medical Diagnoses (including name(s) of intellectual or developmental diagnoses)

Behavioral Health/Psychiatric Diagnoses

List any currently prescribed medications

Name of medication	Dose	Intended Purpose

Please describe patterns of appetite, sleep, bathroom use, and other areas related to biological functioning; particularly note any recent changes.

VII. Family Situation:

Describe any particularly relevant aspect of family circumstances that would be useful to know.

VIII. Considerations/Factors

Please mark all boxes that apply

Types of Challenging Behaviors	Risks	Other Factors
☐ Self-Injury	☐ Is/was Hospitalized/Institutionalized	☐ Lack of Psychiatry
☐ Physical Aggression	☐ High Risk for Hospital/Institution	☐ Impacting Medical Conditions
☐ Property Destruction	☐ Out of Home Placement	☐ Challenges at home
☐ Elopement/ Running Away	☐ Police Involvement	☐ Challenges in the community
☐ Self-Isolation	☐ APS/CPS Involvement	☐ Challenges at school or work
☐ Other: _____	☐ Lost Services (due to behavior)	☐ Isolated Family (few natural supports)
	☐ Housing at risk	
	☐ Vocation at risk	
	☐ High Staff Turnover (due to behavior)	

Other Considerations – Feel free to note any factors not specifically noted above

IX. Life Events

List up to 5 significant life events that may have an effect on the consumer. Indicate approximately when they occurred. Include moves, health issues, and major relationship developments and losses.

1.
2.
3.
4.
5.

X. Other Important Information

Please return completed form to the following address (please note email is highly preferred):

Community TIES program
Waisman Center – Outreach Programs
Attention: Shawn Bass
122 E. Olin Avenue, Suite 255
Madison, WI 53713
Fax: 608-263-468
Send to: sbass@wisc.edu