

AUTISM NEEDS ASSESSMENT



Please note that you must be at least 18 years of age to complete this survey

Thank you for agreeing to complete this survey. Since most respondents will be parents/guardians, we refer to the person with autism as “your child.” The term autism is used to refer to all Autism Spectrum Disorders (ASD). Please complete this survey for your oldest child with autism. Mark only one answer choice per question unless otherwise specified.

1. Please identify yourself:

- Mother
- Father
- Other (*Please specify*) _____
- Foster parent
- Legal guardian

2. Which of the following best describes your current marital status?

- Married to/Living with child’s other parent
- Married to/Living with person other than child’s parent
- Widowed
- Never been married
- Separated/Divorced

3. What is your race/ethnicity? (*Check all that apply*)

- African American
- Asian/Pacific Islander
- Caucasian/European American
- Other (*Please specify*) _____
- Latino, Hispanic, or Chicano
- Native American

4. What is the race/ethnicity of your spouse or significant other? (*Check all that apply*)

- African American
- Asian/Pacific Islander
- Caucasian/European American
- Other (*Please specify*) _____
- Latino, Hispanic, or Chicano
- Native American
- N/A

5. What is your zip code (e.g. 19104)?

6. Which of the following is closest to your annual household income?

- Under \$20,000
- \$20,000-\$39,999
- \$40,000-\$59,999
- \$60,000-\$79,999
- \$80,000-\$99,999
- \$100,000 or above

7. What is your highest level of completed education?

- No high school
- Some high school
- High school graduate/GED
- Vocational/Technical school
- Some college
- College degree
- Some graduate studies
- Graduate degree

8. What is the sex of your child?

- Male
- Female

9. How old is your child? _____ years _____ months

10. Is your child adopted?

- Yes
- No

11. What is his/her race/ethnicity? (*Check all that apply*)

- African American
- Asian/Pacific Islander
- Caucasian/European American
- Latino/Hispanic/Chicano
- Native American
- Other (*Please specify*) _____

12. How many siblings does he/she have? _____

13. How many of those siblings have also been diagnosed with autism? _____

14. What is your child's primary diagnosis?

- Asperger's Disorder
- Autistic Disorder/Autism
- Childhood Disintegrative Disorder
- Pervasive Developmental Disorder (PDD/NOS)
- Rett Syndrome
- Other (*Please specify*) _____

15. Does your child **currently** have any of the following diagnoses? (*Check all that apply*)

- Anxiety Disorder
- Attention Deficit/Hyperactivity Disorder
- Bipolar Disorder
- Central Auditory Processing Disorder
- Conduct Disorder (CD)
- Depression
- Developmental Delays
- Hearing Impairment
- Learning Disability
- Mental Retardation/ Intellectual Disability
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Seizures/ Seizure Disorder/Epilepsy
- None
- Other (*Please specify*) _____

16. Did your child receive any of the following diagnoses **prior** to receiving his/her autism diagnosis?
(*Check all that apply*)

- Anxiety Disorder
- Attention Deficit/Hyperactivity Disorder
- Bipolar Disorder
- Central Auditory Processing Disorder
- Conduct Disorder (CD)
- Depression
- Developmental Delays
- Hearing Impairment
- Learning Disability
- Mental Retardation/ Intellectual Disability
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Seizures/ Seizure Disorder/Epilepsy
- None
- Other (*Please specify*) _____



17. How old was your child when you first became concerned about his/her development?

_____ years _____ months

18. What type of professional first diagnosed your child with autism?

- Developmental Pediatrician
- Educational team (IEP or EI)
- Neurologist
- Primary Care Physician (Family doctor/Pediatrician)
- Psychiatrist
- Psychologist
- Other (*Please specify*) _____

19. About how many miles did you travel for the initial autism diagnosis (roundtrip)?

- 0-20 miles
- 21-40 miles
- 41-60 miles
- 61-80 miles
- 81-100 miles
- More than 100 miles

20. How old was your child when he/she received this diagnosis? _____ years _____ months

21. How many professionals (e.g. psychologist, developmental pediatrician) did you visit before your child received an autism diagnosis? _____

22. After receiving a diagnosis, what sort of follow-up and resources/services did you receive? (*Check all that apply*)

- Follow-up appointment
- Referral to a specialist for further assessment
- Referral to a specialist for treatment
- Referral to Early Intervention services
- Referral to support groups
- Referral to websites, literature (e.g. handouts, information booklets)
- None
- Other (*Please specify*) _____

23. How do you pay for your child’s health care services? (*Check all that apply*)

- Private health insurance
- Medicaid (Medical Access)
- Out-of-pocket
- I don’t know
- Other (*Please specify*) _____

24. In the past year, have you taken your child to the emergency room for behavioral or psychiatric reasons?

- Yes
- No
- On how many occasions? _____

25. In the past year, has your child been admitted to a hospital or hospital-like setting for behavioral or psychiatric reasons?

- Yes
- No
- On how many occasions? _____

If you answered “No” to question 25, please SKIP to question 26

25a. What was/were the reason(s) your child was admitted to a hospital or hospital-like setting? (*Check all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Running away from home/school |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-injurious behaviors |
| <input type="checkbox"/> Defiant/Oppositional behaviors | <input type="checkbox"/> Significant increase in obsessions |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

25b-d. How satisfied or dissatisfied were you with the following aspects of your child's hospital stay?

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
b. Discharge Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Staff's Inclusion of Parent(s) in Treatment Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Quality of Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25e. How was your child admitted?

- My child (under 14) was admitted by his/her parent(s)
- My adolescent child (14 to 18) was admitted by his/her parent(s) and agreed to the admission
- My adolescent child (14 to 18) was admitted by his/her parent(s) but did not agree to the admission
- My adult child (18 or older) admitted him/herself (201, voluntary treatment)
- My adult child (18 or older) was admitted against his/her will (302, involuntary treatment)

Please continue answering the questions

26. In the past year, has your child been placed in a residential facility?

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No and not on a waiting list |
| <input type="checkbox"/> No, but currently on a waiting list | |

If your child has not been placed in a residential facility or is not currently on a waiting list, please SKIP to question 27

26a. About how many miles is this residential facility away from your home?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> 0-20 miles | <input type="checkbox"/> 61-80 miles |
| <input type="checkbox"/> 21-40 miles | <input type="checkbox"/> 81-100 miles |
| <input type="checkbox"/> 41-60 miles | <input type="checkbox"/> More than 100 miles |

Please continue answering the questions

27. What is your child's current living situation?

- | | |
|--|---|
| <input type="checkbox"/> With parent(s) in a family home | <input type="checkbox"/> Group home |
| <input type="checkbox"/> With other relative(s) in a family home | <input type="checkbox"/> Lives on own with support |
| <input type="checkbox"/> Residential facility | <input type="checkbox"/> Lives on own without support |

33. In what ways (if any) has your child's autism affected your family's workforce participation? (Check all that apply)

	Me	My Partner
a. Stopped working outside the home	<input type="checkbox"/>	<input type="checkbox"/>
b. Decreased work hours	<input type="checkbox"/>	<input type="checkbox"/>
c. Increased work hours	<input type="checkbox"/>	<input type="checkbox"/>
d. Changed employer	<input type="checkbox"/>	<input type="checkbox"/>
e. Changed type of work	<input type="checkbox"/>	<input type="checkbox"/>
f. Changed work schedule	<input type="checkbox"/>	<input type="checkbox"/>
g. Changed position with same employer	<input type="checkbox"/>	<input type="checkbox"/>
h. Used Family Medical Leave Act	<input type="checkbox"/>	<input type="checkbox"/>
i. Lost promotion/advancement opportunities	<input type="checkbox"/>	<input type="checkbox"/>
j. Terminated from employment	<input type="checkbox"/>	<input type="checkbox"/>
k. Disciplined/Suspended	<input type="checkbox"/>	<input type="checkbox"/>
l. None	<input type="checkbox"/>	<input type="checkbox"/>
m. Other (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

34. Does your child have an IEP (Individualized Education Plan)?

- Yes
 No
 No, but evaluation complete, waiting for results
 I don't know
 No, but waiting for an evaluation

If your child DOES NOT have an IEP, please SKIP to question 35

34a. How strongly do you agree or disagree with the following statement?

“My child's IEP addresses all of my concerns for my child's development and education.”

- Strongly Agree
 Agree
 Disagree
 Strongly Disagree

34b. Did you or another family member attend your child's last IEP meeting?

- Yes
 No

34c. What is the most recent transition your child has made?

- Elementary School to Middle School
 Middle School to High School
 Other (Please specify) _____

34d. How satisfied are you with the support you received from the IEP team during this transition?



- Very Satisfied
- Somewhat Satisfied
- Somewhat Dissatisfied
- Very Dissatisfied
- N/A

Please continue answering the questions...

35. In what category of special education is your child currently placed? (Check all that apply)

- Autism
- Emotional Support
- Learning Disabilities
- Mental Retardation
- Other (Please specify) _____
- Multiple Disabilities
- None (My child is not receiving special education services)

36. What are your plans for your child's future?

- Four-year college
- Two-year college
- Vocational/Technical school
- Other (Please specify) _____
- Seek employment
- Undecided
- I don't know

37. Is your child capable of the following activities?

	Independently	With Help	Not Capable
a. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeding self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dressing self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Requesting things he/she needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Requesting things he/she wants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Indicating when he/she is sick/hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Cooking/Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Getting around via driving/public transportation/biking/walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38. Does your child have any siblings?

- Yes
- No

Please answer questions 38 a-m in regard to the sibling closest in age to your child with autism, even if this sibling does not have autism.
 If your child does not have any siblings, please SKIP to question 39.

38a. How old is this sibling? _____ years _____ months

38b. What is his/her sex?

Male

Female

38c. Does this sibling currently live in the same home as your child with autism?

Yes

No

38d. What is his/her relationship to your child with autism?

Biological siblings

Half-siblings

Adoptive siblings

Stepsiblings

Other (*please specify*) _____

38e. Does this sibling have any of the following diagnoses? (*Check all that apply*)

Anxiety Disorder

Hearing Impairment

Attention Deficit/Hyperactivity Disorder

Learning Disability

Autistic Disorder/Autism

Mental Retardation/ Intellectual Disability

Bipolar Disorder

Obsessive Compulsive Disorder (OCD)

Central Auditory Processing Disorder

Oppositional Defiant Disorder (ODD)

Conduct Disorder (CD)

Seizures/ Seizure Disorder/Epilepsy

Depression

None of these

Developmental Delays

38f-q. Based on this sibling's behavior in the past six months, how often has he/she demonstrated the following behaviors compared to his/her peers? *"This child ..."*

	Never	Sometimes	Often	Almost Always
f. Was physically aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Was verbally aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Seemed anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Seemed depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Made suicidal threats/comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Exhibited suicidal/self-harming behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Complained that no one loves/cares about him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Complained about his/her sibling with autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Had conflicts with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Had conflicts with his/her sibling with autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Had conflicts with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Had conflicts with authority figures (e.g. principal, teacher)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



39. How strongly do you agree or disagree with the following statements?

“My child is receiving all the regular care he/she needs for...”

	Strongly Agree	Agree	Disagree	Strongly Disagree
a. Primary Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dental Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

“The individuals providing these services are able to meet my child’s needs.”

	Strongly Agree	Agree	Disagree	Strongly Disagree
c. Primary Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dental Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. What limitations do you face accessing primary health care? *(Check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Providers in the area won’t see children with autism |
| <input type="checkbox"/> Scheduling issues | <input type="checkbox"/> Cost of services/My insurance does not cover available services |
| <input type="checkbox"/> Child’s behavior problems | <input type="checkbox"/> None |
| <input type="checkbox"/> Shortage of service providers in the area | |
| <input type="checkbox"/> No service providers in the area | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |

41. What limitations do you face accessing dental services? *(Check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Providers in the area won’t see children with autism |
| <input type="checkbox"/> Scheduling issues | <input type="checkbox"/> Cost of services/My insurance does not cover available services |
| <input type="checkbox"/> Child’s behavior problems | <input type="checkbox"/> None |
| <input type="checkbox"/> Shortage of service providers in the area | |
| <input type="checkbox"/> No service providers in the area | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |

42. Please tell us about your child's service needs:

	My child is receiving	My child is receiving, but needs more	My child is receiving, but does not need	My child is not receiving, but needs	My child is not receiving
a. Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Speech/Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. One-to-one Support (e.g. TSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Mobile Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neurology Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Summer Camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Summer School (ESY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Sexual Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Transitional Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Vocational Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Career Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Academic Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Drug & Alcohol Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Relationship Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. How strongly do you agree or disagree with the following statement?

“The professionals providing this service have the necessary skills to work with my child.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Speech/Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. One-to-one Support (e.g. TSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Mobile Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neurology Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Summer Camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Summer School (ESY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Sexual Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Transitional Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Vocational Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Career Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Academic Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Drug & Alcohol Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Relationship Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

44. How strongly do you agree or disagree with the following statement?

“This service is effective in meeting my child’s needs.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Speech/Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. One-to-one Support (e.g. TSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Mobile Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neurology Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Summer Camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Summer School (ESY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Sexual Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Transitional Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Vocational Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Career Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Academic Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Drug & Alcohol Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Relationship Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



45. What limitations do you face accessing the specialty health and education services mentioned?
 (Check all that apply)

- Transportation
- Scheduling issues
- Child’s behavior problems
- Shortage of service providers in the area
- No service providers in the area
- Providers in the area won’t see children with autism
- Cost of services/My insurance does not cover available services
- None
- Other (Please specify) _____
- Other (Please specify) _____

46. Please tell us about your family support service needs:

	My family is receiving	My family is receiving, but needs more	My family is receiving, but does not need	My family is not receiving, but needs	My family is not receiving
a. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Babysitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Afterschool Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Weekend Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

47. How strongly do you agree or disagree with the following statement?

“The professionals providing this service have the necessary skills to work with my family.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Babysitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Afterschool Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Weekend Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. How strongly do you agree or disagree with the following statement?

“This service is effective in meeting my family’s needs.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Babysitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Afterschool Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Weekend Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

49. What limitations do you face accessing the family support services mentioned? (*Check all that apply*)

- Transportation
- Scheduling issues
- Shortage of service providers in the area
- No service providers in the area
- Cost of services/My insurance does not cover available services
- None
- Other (*Please specify*) _____
- Other (*Please specify*) _____

50. Are there any particular service providers or organizations you would recommend to other individuals? (*Please fill out as much information as possible*)

Type of Service:	
Name of Provider:	
Organization:	
Address:	

Type of Service:	
Name of Provider:	
Organization:	
Address:	

Type of Service:	
Name of Provider:	
Organization:	
Address:	



*Thank you for completing this needs assessment survey.
Please send the completed survey in the self-addressed and stamped envelope.*

