

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
- Other (*Please specify*) _____
- Pervasive Developmental Disorder (PDD/NOS)
- Rett Syndrome

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
- Other (*Please specify*) _____
- Hearing Impairment
- Learning Disability
- Mental Retardation/ Intellectual Disability
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Seizures/ Seizure Disorder/Epilepsy
- None

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
- Other (*Please specify*) _____
- Hearing Impairment
- Learning Disability
- Mental Retardation/ Intellectual Disability
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Seizures/ Seizure Disorder/Epilepsy
- None



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)
- Other (*Please specify*) _____
- Out-of-pocket
- I don’t know

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 |

28. How satisfied or dissatisfied are you with your child's current living arrangement?



- Very Satisfied
 Satisfied
 Dissatisfied
 Very Dissatisfied

29. Is your child receiving therapy or intervention for any of the following issues?

	Yes, and needs it	Yes, but does not need	No, but needs	No, and does not need it
a. Self-injurious behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Aggressive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. In the last year, has your child been disciplined at school in any of the following ways? (Check all that apply)

- Time-out/De-escalation room
 Expulsion
 Sent out of classroom
 None
 Detention
 N/A (My child is not in school)
 In-school suspension
 Out-of-school suspension
 Other (Please specify) _____

31. Has your child's behavior resulted in any of the following interactions with the police? (Check all that apply)

- Police called
 Served time in jail
 Police warning issued
 Served time in a juvenile detention facility
 Child adjudicated
 None
 Other (Please specify) _____

32. What long-term plans do you have for your child when you are no longer able to care for them? (Check all that apply)

- Arranged housing plans
 Designated power of attorney
 Set up financial trust
 Currently developing plans
 Designated guardianship
 None at this time
 Other (Please specify) _____

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 <i>(Please specify)</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

34. What is your child's highest level of completed education?

- | | |
|--|--|
| <input type="checkbox"/> No high school | <input type="checkbox"/> Some college |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> College degree |
| <input type="checkbox"/> High school graduate/GED | <input type="checkbox"/> Some graduate studies |
| <input type="checkbox"/> Vocational/Technical school | <input type="checkbox"/> Graduate degree |

35. Is your child currently in school?

- Yes, four-year college
 Yes, two-year college
 Yes, vocational/technical school
 Yes, graduate school
 No, my child is not in school
 Other *(Please specify)* _____

36. Is your child currently employed?

- | | |
|--|--|
| <input type="checkbox"/> Part-time with support | <input type="checkbox"/> Full-time without support |
| <input type="checkbox"/> Part-time without support | <input type="checkbox"/> Seeking employment |
| <input type="checkbox"/> Full-time with support | <input type="checkbox"/> Unemployed |



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 hurt/sick	<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. 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"/>

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

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

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

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

41. Please tell us about your child's specialty health and education 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 and 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"/>

42. 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 and 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?

“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 and 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. 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 individuals with autism
- Cost of services/My insurance does not cover available services
- None

Other (Please specify) _____

Other (Please specify) _____

45. 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. Adult Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. 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. Adult Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. 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?

“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. Adult Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | |
|--|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Cost of services/My insurance does not cover available services |
| <input type="checkbox"/> Scheduling issues | <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> _____ | |

49. Are there any particular service providers or organizations you would recommend to other parents?
(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.*

