ATLANTA YOUTH SERVICES

Autism Respite Care Services (ARCS)

EMAIL COMPLETED FORM TO: info@atlantayouthservices.com | AYS will contact the caregiver to complete the full intake and consent packet.

1. REFERRAL SOURCE & ELIGIBILITY

Referral date:		**Request:**	☑ Planned ☐ ☑ Emergency ☐ ☑ New ☑ Routine
Referring person/agency:		**Case Manager / contact:**	
Phone:		**Email:**	
SHINES case / referral ID:		**Phone:**	
Eligibility:	☑ Currently in foster care ☐ Adopted/formerly in foster ☑ ☐ Autism diagnosis documented ☐ Age 21 or younger	**Region / county:**	County: _____

2. CHILD / YOUTH & CAREGIVER INFORMATION

Child / youth full name:		**DOB / age:**	
Caregiver name & relationship:		**Caregiver email:**	
Caregiver phone:		**Preferred language:**	
Service address / county:		**Additional Information:**	

3. REQUESTED RESPITE SERVICES & PROVIDER MATCH

Requested start date:		**Dates / days / times requested:**	
Schedule:	☐ One-time ☐ Recurring ☐ Overnight ☐ Multi-day	**Total hours requested:**	(4-hour minimum per request)
Service location:	☐ Caregiver home ☐ Other residence in same DFCS region	**Provider preferences:**	Gender: _____ Pet comfort: _____ Other: _____
Additional staffing may be needed?	☐ No ☐ Yes - explain below / extraordinary	**Transportation:**	AYS providers do not transport children.

4. CHILD PROFILE, SAFETY NEEDS & REASON FOR REFERRAL

Communication / AAC / preferred interaction:	
Important behaviors, triggers, supervision or safety risks:	☐ Elopement ☐ Aggression ☐ Self-injury ☐ Pica ☐ Sexual-safety concerns ☐ Other: _____ Details / what helps:
Health, medication, allergy, feeding, seizure, mobility or personal-care needs:	
Family goals / reason respite is requested now:	

5. REFERRAL CONFIRMATION & SUPPORTING DOCUMENTS

Attach when available:	☐ Autism diagnostic record ☐ Current safety/behavior plan		
Submitted by / title:		**Signature / date:**	

Submission confirms that the information is accurate to the best of the referrer's knowledge and that appropriate legal/agency authority exists to initiate the referral.