

The Vista School[®] School District Referral

Referral Information

Instructions: Please fill out this document to the best of your ability.
Include copies of relevant information where noted.

Areas:

- ◇ Documentation of diagnosis
- ◇ Most recent *Evaluation Report*, child's last two *IEP's*, *Behavior Plans* and any other relevant information
- ◇ Most recent *Medical Assistance (MA) Re-certification Report* and child's last two *Treatment Plans*
- ◇ Information from outside sources such as *Speech-Language Pathologist (SLP)*, *Occupational Therapist (OT)*, *Psychologist*, etc.
- ◇ Completed *Autism Insurance Act Questionnaire* and copy (front and back) of Child's *Private Insurance Card*

The Vista School[®]

School District Referral Information Form

Date: _____ Student's Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ Sex: _____

Student's Medical Assistance Number (10-digit) _____ Race _____

Please provide a copy of child's Medical Assistance Card at screening

Family Contact Person(s): (1) _____ (2) _____

Day Phone: _____ Day Phone: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

E-mail: _____ E-mail: _____

Fax: _____ Fax: _____

Relationship: _____ Relationship: _____

Number of adults in household: _____ Names: _____

Number of children in household: _____ Names: _____

School District: _____ IU: _____

Contact Person: _____

Phone Number: _____ Fax Number: _____

Address: _____

E-mail Address: _____

Clinical diagnosis: _____ Date of diagnosis: _____

Child's age at diagnosis: _____ Performed by: _____

Does the student have a secondary diagnosis and/or other medical conditions? _____

If yes, please list: _____

Is the student currently enrolled in a school/program? _____

If yes...

Name of school/program _____

School district: _____

Special Education Director: _____

Program Description: _____

The Vista School [®]

Is the student on medication? _____

If yes, list medication, dosage, administration times and what medication is used for.

Name of Medication	Dosage	Administration Times	Used for...

Has the student ever been admitted to a hospital or treatment center for a psychiatric, behavioral or crisis situation? _____

If yes, please explain: _____

Please summarize the hospital/treatment facility's observations and treatment(s): _____

Was this treatment effective? _____ Please explain: _____

Additional comments: _____

Signature _____
(School District Representative)

Completion and submission of the referral form to The Vista School's admissions team begins The Vista School screening process. Further, it provides a forum for parents' and school districts' consideration of Vista as part of a continuum of appropriate placement options. Referrals are non-binding to Vista and school districts. The submission of a referral form does not guarantee acceptance or enrollment into Vista's programs.

The Vista Foundation – Autism Insurance Act (Act 62 of 2008) Questionnaire

Child's Name: _____

INSTRUCTIONS: Parents, please answer the “Questions for Parent” below. If your child has private insurance coverage through your employer’s health plan, please complete items 1 through 4 in the “Insurance and Employer Information” section. If your child is enrolled in the PA Children’s Health Insurance Program (CHIP), please complete items 1 and 2 in the “Insurance and Employer Information” Section.

Questions for Parent

1. Is your child covered by private health insurance provided by your employer? Yes No
 - a. If **Yes**, please complete the insurance and employer section below.
 - b. If **No**, proceed to Question 2.

2. Is your child enrolled in the PA Children’s Health Insurance Program (CHIP)? Yes No
 - a. If **Yes**, Act 62 applies to your child. Please complete the insurance section below.

Insurance and Employer Information

1. Name of Employer Offering Coverage _____
2. Name of Parent Employed at Company Offering Insurance _____
3. Insurance Company Name (on Insurance Card) _____
4. Insurance ID # (on Insurance Card) _____
5. Group # (on Insurance Card) _____
6. Name and Phone Number of Your Employer’s HR Director

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FOR VISTA USE ONLY

1. Does the employer have more than 50 persons participating in group? Yes No
2. Is the insurance plan self-funded? Yes No
3. Is the child insured through the PA CHIP program? Yes No
4. Does Act 62 apply to the child’s health insurance plan? Yes No
5. If #4 is “Yes”, enter open enrollment date: _____

QUESTIONS? CALL JIM BOUDER AT (717) 835-0310