

Resource Directory



Provider Listings

Name(s): _____

Professional Title and Initials: _____

Degree(s): _____

Year(s) Earned: _____

Where Earned: _____

Practice/Organization Name: _____

Practice/Organization Address: _____

City, State, Zip: _____

Practice/Org. Telephone: _____ Alternate Telephone: _____

Fax: _____ Email: _____

Names of Associates in Practice/Organization, If Applicable: _____

Services Provided: (Check all that apply)

Advocacy _____

Autism Treatment _____

Consultation To Agencies/Schools _____

Crisis Intervention _____

Diagnostic Evaluation _____

Educational Identification _____

Employment Assistance/Job Training/Adult Disability _____

Native American Resources _____

Primary Health Care _____

Specialist Health Care _____

Resources/Referrals/Support _____

Social Skills Groups _____

Social Services/Low Income Assistance _____

Tutoring _____

Other _____

Professional Category of Services (Check all that apply)

Acupuncture _____

Allergy _____

Audiology _____

Behavioral Therapy _____

Biomedical Treatment _____

Chiropractic _____

Counseling _____

Dentistry _____

Developmental Pediatrics _____

Educational Services _____

Family Medicine _____

Gastroenterology _____

Legal Services _____

Naturopathic Treatment _____

Neurology _____

Nutritionist/Dietician _____

Occupational Therapy _____

Optometry _____

Ophthalmology _____

Oral Surgery _____

Orthodontics _____

Pediatrics _____

Physical Therapy _____

Psychology _____

Psychiatry _____

Sleep Medicine _____

Social Work _____

Speech Language Pathology _____

Vision Therapy _____

Other: _____

Age range which you serve: _____

Fee(s) If Applicable: _____

Are you a Medicaid provider: _____

Private Insurance Companies for which you are a provider: _____

If families lack insurance, do you have a reduced fee?: _____

If diagnostic professional, what diagnostic instruments are you trained to use? (e.g. ADOS, ADI-R, CARS, GARS): _____

If you provide autism treatment, please describe your methods, any certifications and continuing education (Applied Behavioral Analysis, DIR/Floortime, Relationship Development Intervention, etc.): __

Number of years experience working with children on the autism spectrum: _____

Other information you would like to include: _____
