



**Center for Children with Autism
Application for Enrollment
(Ph) 214.333.7032
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I. IDENTIFYING INFORMATION

Child's Name

Date of Birth

Address

City, State

ZipCode

Child lives with:

Mother & Father

Mother

Father

Other/Legal Guardian (please specify) _____

***** guardianship papers must accompany application**

Primary language spoken in the home: _____

Guardian's Name (and address if different than child's)

Home Phone

Work Phone

Cell Phone/Emergency Number

Email Address

Name and address of alternate/emergency contact

Home Phone

Work Phone

Cell Phone/Emergency Number

Email Address

List other children in family:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____

Therapy session that you would like your child to attend. If it would be possible to bring your child to more than one session time, please indicate your preferences in order (ie. 1,2,3)

_____ 9:30-11:30

_____ 1:00 – 3:00

_____ 3:30 – 5:30

****Please note: If the session you are interested in is full, your child will be put on the waiting list.**

Days of the week that you would like your child to attend:

Mon Tues Wed Thurs Fri

Does the child currently receive Metrocare Services? Yes No

If so, which services does he/she receive: _____

Name of Metrocare Services Case Manager/Case Coordinator: _____

Who referred you to us? _____

II. ADAPTIVE BEHAVIOR:

A. Self-Help skills: Independent Verbal Prompts Physical Assistance

Toileting	_____	_____	_____	(Not toilet trained ___)
Dressing	_____	_____	_____	
Eating	_____	_____	_____	
Bathing	_____	_____	_____	
Hand Washing	_____	_____	_____	

B. Verbal/Communication Skills

- No speech sounds
- 3-5 speech sounds
- Babbles – with 3-5 speech sounds
- Babbles with 5+ speech sounds
- Can say at least 10 words
- Echolalia (repeats)
- Uses words or short phrases to communicate wants/needs.

- Primary mode of communication is sign language
- Approximate number of signs

- Primary mode of communication is pictures/PECS
- Approximate number of pictures/PECS

III. BEHAVIOR STATUS

A. Self-stimulatory Behaviors (ex: making noises/repeating phrases, hand flapping, rocking, spinning, heaving breathing)

1. Motor self-stimulation: specify _____

- occurs in most all settings occurs primarily when not engaged by another
- not observed

2. Vocal Self-stimulation: specify _____

- occurs in most all settings occurs primarily when not engaged by another
- not observed

3. Other self-stimulatory behaviors: _____

B. Self-Injury: (specify) _____

- Number of times/day
- Occurs at home
- Occurs at school
- Occurs in all environments

Antecedents (triggers):: _____

C. Aggression to Others: (specify) _____

_____ Number of times/day

_____ Occurs at home

_____ Occurs in all environments

Antecedents (triggers).: _____

D. Other Challenging Behaviors (check all that apply)

_____ Responds negatively to changes in the environment

_____ Pica (eats inedible objects) specify _____

_____ Unauthorized departure (runs off)

_____ Spitting

_____ screaming/tantrums

_____ throwing/breaking objects

_____ self injury (biting/banging)

_____ inattention

_____ hyperactivity

_____ non-compliance

_____ crying

Please describe the problems (circumstances, response to behaviors, etc.): _____

EVALUATIONS -If any of the following evaluations have been conducted, indicate the date and name of professional who administered the test.

	DATE	PROFESSIONAL
1. Psychological and/or Educational Evaluation	_____	_____
2. Speech and Language Assessment	_____	_____
3. Visual Examination	_____	_____
4. Hearing Evaluation	_____	_____
5. Neurological Evaluation	_____	_____
6. Medical Evaluation	_____	_____

CURRENT THERAPIES:

	Yes	No	Number times/week
Speech/language therapy	Yes	No	_____
Occupational therapy	Yes	No	_____
ABA therapy	Yes	No	_____

Other: _____

MEDICAL: My child has in-depth medical attention for the following conditions(s).

****Do NOT include routine illnesses:**

Allergies: _____

—

Child's Physician's Name Address Telephone Number

Education History

SCHOOL HISTORY – List all schools attended by grade and year:

	Grade	School Year	School
Current:	_____	_____	_____
Past:	_____	_____	_____
Past:	_____	_____	_____

Describe any difficulties: _____

Does child seem to have friends? Yes No Can child follow directions at school? Yes No

Medical History

Has child been back in the hospital since birth? Yes No

Explain: _____

Has child had any unusual injuries or serious illness?

Does child have allergies? Yes No

Explain: _____

Frequent colds? _____ Does child take medication regularly? If so, why? _____

Has child had hearing tested? Yes No When? _____

Results? _____

Does child have ear tubes? Yes No

Do you feel your child's general health has been

Poor fair good excellent?

General Information

What are your child's favorite activities?

Has your child ever been involved in an ABA program? Yes No If so, briefly explain the program: _____

—

Service

Provider/Consultant: _____

Locations/Dates: _____

—

Names of

trainers: _____

Goals

accomplished: _____

Parent Information

Are parents: ___ married ___ separated ___ divorced

Who has custody of child? _____

Father's occupation? _____ level of education? _____

Place of employment? _____

Mother's occupation? _____ Level of education? _____

Place of employment? _____

If both parents work, what are child care arrangements:

******A current copy of your child's Immunization Records MUST be provided prior to the first day of attendance.**

I affirm that the information in this application is a complete and true statement of all the facts and circumstances relative to my child's application for enrollment.

Parent/Guardian Signature

Date



Metrocare – *the provider of choice*