



Come to learn
Come to grow
Come to celebrate

Dear Interested Parent(s),

Thank you for taking interest in the Minnesota Autism Center (MAC). MAC is a non-profit organization founded by parents of children with autism, in part, because of the institutional and social discrimination faced by developmentally disabled children. MAC promotes participation with families and peers and the development and support of healthy families. *Our mission is to promote the accessibility of early, intensive home and school based behavioral therapy for children and youth with Autism Spectrum Disorders (ASD) and to promote the general education and welfare of persons challenged by Autism Spectrum Disorders (ASD).* We provide the following services:

Intensive In-Home Early Intervention Program

This service is provided in the home. It consists of one-on-one ABA (Applied Behavior Analysis) therapy and instruction based on discrete trial and other functional instruction. Data-based analysis, systematic generalization of skills, and individualized goals and objectives are incorporated into the program to best meet the needs of your child. This intensive program requires a mandatory 25+ hours of therapy per week and includes parental involvement. **A parent or responsible party is required to be in the home while therapists are working with the child.** The supervising MAC Psychologist will make the final determination regarding the number of therapy hours required.

School Age Program

This service is also provided in the home, school, or community setting. This service consists of one-on-one ABA (Applied Behavioral Analysis) therapy to improve social and behavioral classroom skills, as well as age appropriate social and play skills with peers. The program collaborates with classroom teachers to ensure the instructional environment maximizes success. The services are coordinated between school and the home, require a mandatory 15+ hours of therapy per week, and include parental involvement. **A parent or responsible party is required to be in the home when therapists are working with the child in that setting.** The supervising MAC Psychologist will make the final determination regarding the number of therapy hours required.

Center-Based Program

This service is provided in our center, located in our corporate headquarters. This service consists of full and half day programs of ABA (Applied Behavioral Analysis) therapy in both a one-on-one and group setting. Enrollment in full and half day programs require a mandatory 15+ hours of therapy per week and include parental involvement. The supervising MAC Psychologist will make the final determination regarding the number of therapy hours required and the appropriate program for the child.

We strive to make the application process as stress-free and efficient as possible. The first step in the process is for you to review all of the enclosed information and sign where applicable. When returning the information, please include copies of any recent psychological/speech/school evaluations. All information will be kept confidential.

Once received, all information will be promptly reviewed and processed. You will be contacted to discuss any questions or concerns that arise. Upon availability, you will be asked to come to our corporate headquarters to have a Licensed Psychologist conduct an assessment to determine eligibility for services. If your child is eligible for services, they will be placed on our waitlist. Our waitlist is extensive and does not work on a first on – first off basis. Since our services are provided in a variety of settings; location, staffing, and availability are all key factors. It is difficult to predict when there will be an opening in a specific area. We encourage you to research other programs to determine what is best for your child.

MAC accepts most commercial insurance, when Mental Health benefits are included in the plan; however, many commercial insurance plans do not cover Mental Health. In those cases, certain Medical Assistance (MA) programs cover the cost of services provided by MAC, specifically straight MA (MA not attached to a commercial plan) or the TEFRA option. For MA information, contact a county caseworker.

Again, thank you for taking interest in our program. If you have any questions please feel free to contact us.

Kelsey Granowski
Intake & Staffing Coordinator
Minnesota Autism Center
952.767.4204
kgranowski@mnautism.org

If interested in an assessment/evaluation **only**, indicate with a check here _____

Intensive In-Home or Center- Based Programs

Child's Availability

Parent Name _____ Child Name _____

****WE REQUIRE A COMMITMENT OF 40 HOURS A WEEK (MONDAY-FRIDAY 8AM-7PM) FOR OUR IN-HOME AND CENTER BASED PROGRAMS. YOUR CHILD MAY BE RECOMMENDED A LOWER NUMBER OF HOURS; HOWEVER, YOU NEED TO AGREE BE AVAILABLE FOR 40 HOURS OF THERAPY IN ORDER TO BE PLACED ON OUR WAITLIST.**

By signing, I agree that we are able to dedicate 40 hours a week to therapy with MAC.

Signature

Date

****Please also be aware that a parent or responsible party must be present in the home while therapy is being provided.**

PLEASE CHECK ONE OF THE FOLLOWING OPTIONS:

_____ We are interested in In-Home services **ONLY**.

_____ We are interested in Center services **ONLY**.

_____ We are interested either In-Home **OR** Center services.

Client Information

Date Packet Completed _____

Contact Information

Child's Name _____ Social Security Number _____

Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

County _____

Referred by (if applicable) _____

Parent or Guardian 1

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Alternative Phone _____

Relationship _____

Social Security Number _____

Date of Birth _____

Occupation _____

Years of Schooling Completed:

did not complete high school

high school graduate

2 year college graduate

4 year college graduate

graduate level education

Parent or Guardian 2

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Alternative Phone _____

Relationship _____

Social Security Number _____

Date of Birth _____

Occupation _____

Years of Schooling Completed:

did not complete high school

high school graduate

2 year college graduate

4 year college graduate

graduate level education

Preferred Method of Contact

Home Phone Number _____

Work Phone Number _____

Email _____

Preferred Method of Contact

Home Phone Number _____

Work Phone Number _____

Email _____

Has your child ever lived outside of your home or away from you for any period of time? _____

When? _____ With whom? _____

Federal Reporting Demographic Information (optional)

Race/Ethnicity (Check all that apply)

White Black or African American

American Indian or Alaskan Native

Asian Native Hawaiian or other Pacific Islander

Other

Are you Hispanic or Latino? Yes No

Primary Language _____

Potential Payment Information (attach copy of both sides of insurance card)

Primary Insurance Provider _____ Policy Number _____

Primary Insurance Provider Phone Number _____

Primary Insurance Provider Contract Renewal Date _____

Secondary Insurance Provider _____ Policy Number _____

Secondary Insurance Provider Phone Number _____

Secondary Insurance Provider Contract Renewal Date _____

Medical Assistance-needs to be straight MA (without a Health Plan) or TEFRA

Medical Assistance Number _____

Emergency Information

Emergency Contact _____ Relationship _____

Address _____ Phone _____

Doctor _____

Address _____ Phone _____

Service and Allied Service Providers

County Case Manager _____

Address _____ Phone _____

Service Provider _____

Address _____ Phone _____

Allied Service Providers (i.e., occupational, speech and/or physical therapy)

Address _____ Phone _____

School _____ **Teacher(s)** _____

Address _____ Phone _____

Type of class:

- None
- Early Childhood Special Education (ECSE)
- Early Childhood Family Education (ECFE)
- Regular Education-Preschool
- Autism Classroom-Preschool
- Special Education-Preschool
- Regular Education Classroom
- Regular Education Classroom with Special Help
- Special Education Classroom
- Autism Classroom
- Special School

Did you receive Behavior Therapy services prior to your start date with MAC?

Yes _____ No _____ If yes, how many hours per week? _____

Environmental Information:

Does a smoker currently reside in your home? Yes _____ No _____

Does a pet currently reside in your home? Yes _____ No _____

Who currently lives in the home? _____

CONFIDENTIAL PARENT QUESTIONNAIRE

Child's Name _____ Date of Birth _____

Name of person completing questionnaire _____ Relationship to Child _____

Date _____

Medical Information

Current Diagnosis _____ Date of Diagnosis _____

Clinic/ Hospital _____

Doctor/ Examiner _____ Phone Number _____

Allergies _____

Medications _____

MAIN CONCERNS

Please list your major concerns in the following areas, comment briefly, and rate them as indicated:	SEVERITY		
	Mild	Moderate	Severe
<u>Social skills and interactions and relationships with peers and family members:</u>			
<u>Communication and language</u>			
<u>Narrow interests, repetitive behaviors or routines that cause problems</u>			
<u>Behavior and self-regulation:</u>			
<u>Play Skills:</u>			
<u>Emotional concerns:</u>			
<u>Self esteem:</u>			

Has your child had any of the following tests or evaluations?	Yes	Date	No	Where was it done? What were the results?
Psychology or neuro-psychology evaluation (Please include copies)				
Brain wave test, EEG, electroencephalogram				
CT or MRI of the head				
Blood chromosome test				
Blood test for fragile X syndrome Former evaluation(s) for autism (Please include copies)				

Family History

Has anyone in the family had:	Yes	No	Parents or siblings of your child (please specify whom)	Grandparents, aunts, uncles, cousins of your child (please specify whom)
Autism				
Mental retardation				
Impaired language or language disorders				
Severe communication problems				
Severe social problems (specify)				
Mental health problems (specify)				

CHILD'S DEVELOPMENTAL HISTORY

By what age did your child sit alone quite steadily for several minutes?	Before 5 months	5-9 months	10 months or later	Not yet
By what age did your child walk alone?	Before 9 months	9-17 months	18 months or later	Not yet
By what age did you child have the first 5-6 words?	Before 8 months	8-12 months	12 months or later	Not yet
How old was your child when s/he first said something that involved putting words together meaningfully (two- or three-word phrases including a verb)? What did s/he say?	Before 24 months	24-33 months	33 months or later	Not yet
At what age did your child gain consistent urine control during the day?	2 ½ years or earlier	2 ½ -4 years	4 years or more	Not yet
At what age did your child gain consistent bowel control over accidents and soiling?	2 ½ years or earlier	2 ½ -4 years	4 years or more	Not yet
Please list any concerns you have about your child's development not already mentioned above:				
Briefly describe your child's infancy (for example, sleeping, eating, crying habits, easy or difficult to care for):				
Briefly describe your child's toddler years (for example, language use, play with other children, temper tantrums, sleep problems, easy or difficult to care for, ease or difficulty when routines changed):				
Briefly describe your child's preschool years (for example playing well with other children, behavior problems, language skills, activity preferences):				
Briefly describe the time of your initial concerns about your child, what those concerns were , and who you took your child to see about them:				

Never	Rarely	Sometimes	Often	Always
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SOCIAL DEVELOPMENT				
Does your child:				
Look you directly in the face when doing things with you or talking with you and respond to your attempts to catch his/her eye?				
Smile in greeting when approaching someone to get them to do something or talk to them, and does your child smile back at someone smiling at them?				
Show a normal range of facial expressions to communicate, such as joy, anger, fear, pain, surprise, guilt, disgust, interest, amusement, and embarrassment?				
If your child has problems with non-verbal behaviors that interfere with social interactions, please give examples (such as avoiding eye contact or failing to respond to smiles, etc):				
Does your child:				
Show interest in watching and interacting with children of the same age?				
Respond appropriately when another child approaches and make an effort to keep the interaction going?				
Participate in group play with children of the same age, attending to peers and modifying his/her behavior to demonstrate spontaneous, flexible, interactive play?				
If your child fails to establish relationships appropriate for his or her developmental level, please give examples (such as showing no interest in other children, avoiding approaches of other children, seeking no participation in group play, showing interest only in siblings or older children, etc):				
Does your child show you things that interest him/her, purely to share interest?				
If your child does not share interests or enjoyment with you or others, please give examples (such as rarely making social approaches, only bringing things associated with preoccupations, only bringing things when needs help, etc.):				
Does your child:				
Consistently respond to the approaches of adults other than parents in familiar situations?				
Ever try to comfort you if you are sad or ill in an attempt to make you feel better?				
If your child has problems with social or emotional reciprocity (such as not responding to others, responding only in a stereotyped fashion, or not noticing when others are hurt or upset) please give examples:				
COMMUNICATION				
Does your child use phrases with at least three words on a daily basis, and understand most developmentally appropriate language if you don't gesture?				
Please give examples of how your child lets you know if he/she wants something:				
If your child does speak, can you have a conversation with him/her at their language level, where they build on your responses?				
4				

If your child has difficulty with reciprocal conversation , please give examples (fails to follow anyone else's conversational topic, asks or answers questions but not as part of an ongoing interchange):					
Does your child use odd phrases or say the same thing over and over in almost exactly the same way, in a nonsocial way?					
If your child exhibits stereotyped utterances or delayed echolalia please give examples (such as repeating phrases he/she has heard other people use, repeating phrases he/she has made up, using phrases not to mean anything in particular, making a running commentary on his/her own actions, repetitively rerunning upsetting interchanges, etc):					
Does your child:					
Play any pretend games, using varied actions or objects to represent things not present?					
Play imaginative games with someone else, incorporating his/her own ideas as well as the other child's?					
Please give examples of your child's typical play:					

	Never	Rarely	Sometime	Often	Always
RESTRICTED, REPETITIVE BEHAVIORS, INTERESTS OR ACTIVITIES					
Does your child seem to be more interested in a certain part of a toy rather than using the toy as it was intended?					
Does your child have any unusual or peculiar interests that preoccupy him/her and might seem odd to other people?					
If your child has these unusual preoccupations, please give examples (such as unusual interest in metal objects, lights, street signs, or toilets):					
Does your child seem to have to do certain things in a very particular way or order (other than bedtime routines)?					
If your child exhibits non-functional routines or rituals, please give examples (such as touching particular things, putting things in special places, opening all doors to a certain angle, turning all lights off, laying his/her napkin out flat and placing the spoon on it before eating, etc.):					
Does your child have any mannerisms or odd ways of moving his/her hands or fingers, or any complicated movements of her/his whole body (other than nail biting, hair twisting, thumb sucking, clapping, or rocking)?					
If your child has these repetitive motor mannerisms, please give examples (such as twisting or flicking his/her fingers in front of their eyes, spinning, repeatedly bouncing up and down, arm waving while rocking up on tiptoes, etc.):					

If your child is in school please comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with parents					
Relationship with siblings					
Relationship with peers					
Participation in organized activities (e.g., teams)					

Describe any current/past treatments:

Describe your child's main strengths:

Describe your child's main problems in more detail (please be specific). How long have they been going on? When are they better or worse? Please give examples of each problem.
 What do you think is causing these problems?

Why are you coming for help at this particular time? What areas do you currently need the most help with?

Please return to:

Minnesota Autism Center
 Attn: Kelsey Granowski
 5710 Baker Road
 Minnetonka, MN 55345
 952.767.4204
 Fax 952.767.4211

Crisis Numbers and Hotlines

Twin Cities Crisis Connection	612-379-6363
United Way First Call for Help, Minnesota	211 or 1-800-543-7709
Hennepin County	612-335-5000
Ramsey, Dakota and Washington County	651-224-1133
Autism Society of America	800-3-Autism
Support 4 Hope Crisis Number, Minnesota	800-854-9001
Crisis Intervention Center	612-347-3161
National Center for Kids Overcoming Crisis	800-8KID-123
MN Association for Children's Mental Health	651-644-7333
Advocacy, answers and support network	800-528-4511
Covenant House 9 line	800-999-9999
Respite for Children with Special Needs:	
Family Focus, Minneapolis	612-331-4429
Family Focus, Austin	507-434-3586
Family Focus, Rochester	507-286-7877
Fraser Child and Family Center	612-861-1688
St. David's Child Development and Family Services	952-939-0396

Crisis Nurseries (infant to 12-years-old):

CAP Agency Crisis Nursery, Shakopee	612-839-5101
Child Care Resource and Referral Crisis Nursery of Olmsted County	507-287-1499
Crisis Nursery of Anoka County	763-785-9222
Children's Home Crisis Nursery serving Chisago and Isanti Counties	651-674-8569
Children's Home Crisis Nursery of Dakota County	952-432-5528
Crisis Nursery of Ramsey County	651-641-1300
Children's Home Crisis Nursery of Wright County	763-682-7410
Crisis Nursery of Sherburne County	763-241-2600
St Cloud Area Crisis Nursery	320-654-1090
Greater Minneapolis Crisis Nursery	763-591-0100
Rice County Crisis Nursery	507-332-6255

For Children over 12:

The Bridge	612-377-8800
PATH	651-641-0455

Consent for the Release of Confidential Information

Consumer's Name: _____ **Date of Birth:** _____

Date: _____ **Legal Representative:** _____

I hereby give my informed consent for the following individual/entity:

_____ to release and exchange information with each other and for MAC to release and exchange information to the above named individuals and entities.

The information that may be released and exchanged includes:

- Psychological Reports/Tests
- Results of Observations
- Diagnostic Information
- Risk Management Plans
- Support Services Plans and Data
- Annual and Quarterly Reports
- Healthcare Information
- Account Information
- Discharge Report
- Treatment Plans

The information will be released or exchanged for the following purposes:

- Planning Treatment Services and Care
- Coordinating Treatment Services and Care

This consent will expire in one year unless consent is withdrawn in writing before that date.

By signing I acknowledge that I have been informed as to who will receive the information and what will be released and exchanged, and what the information will be used for. I understand what will happen if I do not or do give my consent. The information that will be released and exchanged is private and confidential. Any further release/exchange is governed by the Minnesota Government Data Privacy Act (Minn. Stat. Chap. 13, as amended) and the Health Insurance Portability and Accountability Act. I understand that I may withdraw my consent at any time by giving written notice (this cannot be retroactive).

(Parent/Legal Representative) Date

(Parent/Legal Representative) Date

(Please print name) Date

(Please print name) Date