Dear Interested Parent(s)/Guardian(s),

Thank you for taking interest in the Minnesota Autism Center (MAC). MAC is a nonprofit 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 home, center 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).

All MAC programs include development of Individualized Treatment Plans utilizing the Skills® curriculum. The Skills® curriculum was developed by researchers through the Center for Autism and Related Diseases (CARD), and is designed to address critical areas of human functioning across eight distinct domains: social, motor, language, adaptive skills, play skills, executive functioning, cognition, and primary concepts. This nationally-recognized curriculum allows for ongoing assessment of your child’s current abilities and needs throughout his/her time at MAC. The Skills® curriculum is employed in all of the following services:

**In-Home Intervention Program**
This service is provided in the home. It consists of one-on-one ABA (Applied Behavior Analysis) therapy based on discrete trial and functional instruction. This program is designed to best meet the needs of your child through data-based analysis, systematic generalization of skills, and individualized goals and objectives. A parent or responsible party over the age of 16 is required to be in the home while therapists are working with your child. For in-home services, your child will be recommended for either full-time or part-time hours. Full-time hours operate Monday through Friday from 8:00-12:00 and 1:00-5:00, while part-time hours run Monday through Friday either 8:00-12:00 or 1:00-5:00. The Clinical Supervisor will make the final determination regarding the required number of therapy hours after the assessment for services has been completed.

**Center-Based Program**
This service is provided in one of our center facilities. Center locations and photos are available on MAC’s website, mnaautism.org. Center-based services consist of one-on-one ABA (Applied Behavior Analysis) therapy based on discrete trial and functional instruction. This program is designed to best meet the needs of your child through data-based analysis, systematic generalization of skills, and individualized goals and objectives. Each of our center programs operate on a full-time basis. Center-based program hours are Monday through Friday 8:30 am to 4:30 pm. The Clinical Supervisor will make the final determination regarding the appropriate program after the assessment for services has been completed.

**Skills Development Center I and II (SDC)**
This service is provided in one of our SDC facilities and consists of ABA (Applied Behavioral Analysis) therapy in both one-on-one and group settings. The SDC focuses on adolescents and combines intensive therapy, life skills and social skills. The focus of SDC programming is to provide functional and purposeful skill sets through programming in a variety of domains, including social, language, executive functioning, adaptive, and vocational skills. SDC programming is designed to help increase environmental awareness, functional communication and independence in daily living. Enrollment in the SDC program requires full-time hours and includes parental involvement. SDC I and II program hours are Monday through Friday 8:30 am to 4:30 pm. The Clinical Supervisor will make the final determination regarding the appropriate program after the assessment for services has been completed.
MAC School Program

This service is provided in the MAC school setting in Eagan. MAC School services consist of one-on-one ABA (Applied Behavioral Analysis) therapy to improve social and behavioral skills in a group setting, as well as age-appropriate social and peer play skills. Due to the group environment in which MAC School services are provided, there are several requirements that need to be in place prior to attending this program. These requirements allow us to ensure safety of and maximize attending ability for all clients within the program, and include being fully toilet-trained, as well as possessing an ability to maintain in a group environment with minimal disruptive behaviors. MAC School clients are divided into age-appropriate grade levels, currently serving grade 3 through age 21. Each grade has a Lead Therapist and a teacher who work concurrently to provide therapeutic services and group instruction across a variety of subject areas. The MAC Eagan campus consists of two buildings: Building A which currently houses 3rd-8th grade, and Building B which includes 9th grade through high school. Enrollment in the MAC school program requires full-time hours and includes parental involvement. The Clinical Supervisor will make the final determination regarding the appropriate program after the assessment for services has been completed.

Assessment Center

MAC offers diagnostic assessment services for autism spectrum disorder (ASD). This service is provided at our assessment facility in Minnetonka. If you are seeking a diagnostic assessment for your child, please check the ‘assessment only’ option on page 3 of the intake packet. If your child is diagnosed with ASD and the Clinical Supervisor recommends MAC services, your child can be placed on a waiting list for the appropriate program at your request.

We strive to make the application process as stress-free and efficient as possible. The first step in the process is for you to respond to all questions in this packet 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 we have received your information, it will be reviewed and processed shortly thereafter. You will be contacted to discuss any questions or concerns that arise during review of your information. If, after review, it is determined that your child may be appropriate for services, he/she will then be placed on our waitlist. We will be in contact with you via standard mail throughout this process. Our waitlist is extensive, and since our current clients aren’t provided services for a definitive amount of time, we are unable to predict what the wait time will be for your child. We encourage you to research other programs to determine what is best for your child. Upon availability, you will have a licensed professional conduct an assessment to determine the appropriate services for your child.

MAC programs are funded through insurance. MAC accepts most commercial insurance, when mental health benefits are included in the plan. Certain Medical Assistance (MA) programs cover the cost of services provided by MAC as well, specifically straight MA (MA not attached to a commercial plan) or the TEFRA option. You **MUST** carry insurance coverage at all times for your child while in a MAC program and are required to carry secondary insurance when needed. For MA information, contact a county caseworker.

Therapy dogs are not allowed on MAC properties.

Again, thank you for taking interest in our program. Please feel free to contact us with any questions.

Miranda Melton  
Intake Director  
Minnesota Autism Center  
952.767.4204  
mmelton@mnautism.org
If interested in an assessment/evaluation only, indicate with a check here_____

Intensive In-Home or Center- Based Programs

Parent Name______________________ Child Name____________________

**WE REQUIRE A COMMITMENT OF FULL TIME HOURS PER WEEK FOR OUR IN-HOME AND CENTER BASED PROGRAMS. YOUR CHILD MAY BE RECOMMENDED A LOWER NUMBER OF HOURS; HOWEVER, YOU WILL NEED TO AGREE TO BE AVAILABLE FOR FULL TIME HOURS OF THERAPY IN ORDER TO BE PLACED ON OUR WAITLIST.

By signing, I agree that we are able to dedicate full time hours per week to therapy with MAC.

Signature __________________________ Date __________

** Please also be aware that a parent or responsible party over the age of 16 must be present in the home while therapy is being provided.

** If your child is receiving Speech and/or Occupational Therapy services through another agency, your child will not be eligible to receive these therapies through MAC unless services are discontinued through the other agency.

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.
We are interested in MAC school services ONLY.

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 Parent or Guardian 2
Name________________________________________ Name________________________________________
Address____________________________________
City________ State____ Zip________
Home Phone________________________
Alternative Phone____________________
Relationship________________________
**Social Security Number______________** Social Security Number ______________
**Date of Birth____________________** 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 ________________________________

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___________________________
Sex ____ Male   ____ Female

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_________________________________________ Phone________________________________________
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?______________________________________
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

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td>Social skills and interactions and relationships with peers and family members:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Communication and language</td>
<td></td>
<td></td>
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<tr>
<td>Narrow interests, repetitive behaviors or routines that cause problems</td>
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<tr>
<td>Behavior and self-regulation:</td>
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<td></td>
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<tr>
<td>Play Skills:</td>
<td></td>
<td></td>
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<tr>
<td>Emotional concerns:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Self esteem:</td>
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<td></td>
<td></td>
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</tbody>
</table>
Has your child had any of the following tests or evaluations?

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Yes</th>
<th>Date</th>
<th>No</th>
<th>Where was it done?</th>
<th>What were the results?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology or neuro-psychology evaluation (Please include copies)</td>
<td></td>
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<tr>
<td>Brain wave test, EEG, electroencephalogram</td>
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<tr>
<td>CT or MRI of the head</td>
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<tr>
<td>Blood chromosome test</td>
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<tr>
<td>Blood test for fragile X syndrome</td>
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<tr>
<td>Former evaluation(s) for autism (Please include copies)</td>
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</tbody>
</table>

Family History

<table>
<thead>
<tr>
<th>Family History</th>
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</thead>
<tbody>
<tr>
<td>Has anyone in the family had:</td>
</tr>
<tr>
<td>Autism</td>
</tr>
<tr>
<td>Mental impairment or disability</td>
</tr>
<tr>
<td>Impaired language or language disorders</td>
</tr>
<tr>
<td>Severe communication problems</td>
</tr>
<tr>
<td>Severe social problems (specify)</td>
</tr>
<tr>
<td>Mental health problems (specify)</td>
</tr>
</tbody>
</table>
### CHILD’S DEVELOPMENTAL HISTORY

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Age in</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>By what age did your child sit alone quite steadily for several minutes?</td>
<td>Age in Months:</td>
<td>Not yet</td>
<td></td>
</tr>
<tr>
<td>By what age did your child walk alone?</td>
<td>Age in Months:</td>
<td>Not yet</td>
<td></td>
</tr>
<tr>
<td>By what age did you child have the first 5-6 words?</td>
<td>Age in Months:</td>
<td>Not yet</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>Age in Months:</td>
<td>Not yet</td>
<td></td>
</tr>
<tr>
<td>At what age did your child gain consistent urine control during the day?</td>
<td>Age in Years:</td>
<td>Not yet</td>
<td></td>
</tr>
<tr>
<td>At what age did your child gain consistent bowel control over accidents and soiling?</td>
<td>Age in Years:</td>
<td>Not yet</td>
<td></td>
</tr>
</tbody>
</table>

**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:
## SOCIAL DEVELOPMENT

<table>
<thead>
<tr>
<th>Does your child:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td></td>
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<tr>
<td>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?</td>
<td></td>
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<tr>
<td>Show a normal range of facial expressions to communicate, such as joy, anger, fear, pain, surprise, guilt, disgust, interest, amusement, and embarrassment?</td>
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</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Does your child:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show interest in watching and interacting with children of the same age?</td>
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<tr>
<td>Respond appropriately when another child approaches and make an effort to keep the interaction going?</td>
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<tr>
<td>Participate in group play with children of the same age, attending to peers and modifying his/her behavior to demonstrate spontaneous, flexible, interactive play?</td>
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</tbody>
</table>

**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):**

<table>
<thead>
<tr>
<th>Does your child:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show you things that interest him/her, purely to share interest?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**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.):**

<table>
<thead>
<tr>
<th>Does your child:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently respond to the approaches of adults other than parents in familiar situations?</td>
<td></td>
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<tr>
<td>Ever try to comfort you if you are sad or ill in an attempt to make you feel better?</td>
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</tbody>
</table>

**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:**


<table>
<thead>
<tr>
<th>COMMUNICATION</th>
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</thead>
<tbody>
<tr>
<td>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?</td>
</tr>
<tr>
<td><strong>Please give examples of how your child lets you know if he/she wants something:</strong></td>
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</tbody>
</table>

| If your child does speak, can you have a conversation with him/her at their language level, where they build on your responses? |

| 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): |

<table>
<thead>
<tr>
<th>Does your child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Play any pretend games, using varied actions or objects to represent things not present?</td>
</tr>
<tr>
<td>Play imaginative games with someone else, incorporating his/her own ideas as well as the other child’s?</td>
</tr>
<tr>
<td><strong>Please give examples of your child’s typical play:</strong></td>
</tr>
</tbody>
</table>
RESTRICTED, REPETITIVE BEHAVIORS, INTERESTS OR ACTIVITIES

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child seem to be more interested in a certain part of a toy than using the toy as it was intended?</td>
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<tr>
<td>Does your child have any unusual or peculiar interests that preoccupy him/her and might seem odd to other people?</td>
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<tr>
<td>If your child has these unusual preoccupations, please give examples (such as unusual interest in metal objects, lights, street signs, or toilets):</td>
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<tr>
<td>Does your child seem to have to do certain things in a very particular way or order (other than bedtime routines)?</td>
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<tr>
<td>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.):</td>
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<tr>
<td>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)?</td>
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<tr>
<td>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.):</td>
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</tbody>
</table>

EDUCATIONAL SERVICES If your child is or has been in school please comment on the areas below:

<table>
<thead>
<tr>
<th>Past Educational Services</th>
<th>Present Educational Services</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Comments
If your child is or has been in school please comment on the areas below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall school performance</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
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<tr>
<td>Writing</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mathematics</td>
<td></td>
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<tr>
<td>Relationship with parents</td>
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<tr>
<td>Relationship with siblings</td>
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<tr>
<td>Relationship with peers</td>
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<tr>
<td>Participation in organized activities (e.g., teams)</td>
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</tbody>
</table>

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: Miranda Melton
5710 Baker Road
Minnetonka, MN 55345
Phone: 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 Minnesota Autism Center 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

5710 Baker Road/Minnetonka, MN 55345/952-767-4200/952-767-4211 (fax)/www.mnautism.org

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