Minnesota Autism Center

952-767-4200
952-767-4211
www.mnautism.org

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

Thank you for your 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. Our mission is to promote the accessibility of home, center and school based behavioral therapy for children, youth and adults with Autism Spectrum Disorders (ASD) and to promote the general education and welfare of persons challenged by 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:

Center-Based Program (Early Intervention Center)
This service is provided in one of our center facilities. Center locations and photos are available on MAC's website at www.mnautism.org/about-mac/our-locations. Center-based services consist of one-on-one ABA 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 and include parental involvement. 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 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 therapy to improve social and behavioral skills in a group setting, as well as age-appropriate social and peer play skills. 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 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 through 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 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 receives an ASD diagnosis and the Clinical Supervisor recommends MAC services, your child can be placed on a waiting list for the appropriate program upon 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 services may be appropriate for your child, he/she will then be placed on our waiting list. 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, a licensed professional will conduct an assessment to determine the appropriate service 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 Center- Based ABA Therapy Programs

Parent Name_____ Child Name_____

ALL MAC PROGRAMS ARE CENTER-BASED THERAPIES, AND REQUIRE A FULL-TIME COMMITMENT OF APPROXIMATELY 40 HOURS PER WEEK. YOU WILL NEED TO AGREE FOR YOUR CHILD TO BE AVAILABLE FOR FULL-TIME THERAPY HOURS IN ORDER FOR HIM/HER TO BE PLACED ON THE WAITLIST FOR SERVICES.

*By signing below, I agree that we are able to dedicate full time hours weekly to therapy with MAC.*

_____

Signature Date

*Please note that MAC offers internal Speech and Occupational therapies for its ABA clients. 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 Center-Based services.

_____ We are interested in MAC School services **ONLY.** (Eagan, MN)

**Please note MAC School clients must be at least eight years of age and meet additional requirements*

_____ We are interested in Center-Based **or** MAC School 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

**Preferred Method of Contact**

Home Phone Number _____

Work Phone Number _____

Email _____

**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 _____

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)**

**Child's Race/Ethnicity (Check all that apply)**

____White ____Black or African American

____American Indian or Alaskan Native

____ Asian ____Native Hawaiian or other Pacific Islander

____Other

Is your child Hispanic or Latino? _____ Yes _____ No

Primary Language_____

**Child's 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_____

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

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

| 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 impairment or disability | | | | |
| 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? | Age in Months: | | | Not yet |
| By what age did your child walk alone? | Age in Months: | | | Not yet |
| By what age did you child have the first 5-6 words? | Age in Months: | | | 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? | Age in Months: | | | Not yet |
| At what age did your child gain consistent urine control during the day? | Age in Years: | | | Not yet |
| At what age did your child gain consistent bowel control over accidents and soiling? | Age in Years: | | | 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 |
|---|---|---|---|---|---|
| **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? | | | | | | |
| **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 | Sometimes | 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.): | | | | | |

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

| Past Educational Services | Present Educational Services |
|---|---|
| | |
| Comments | |

| If your child is or has been 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: 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** |