Minnesota Autism Center
952-767-4200
952-767-4211
www.mnautism.org

Intensive Center- Based Therapy Programs

Parent Name_____ Child Name_____

Please note that MAC offers Speech and Occupational therapies for its 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 <u>ONE</u> OF THE FOLLOWING OPTIONS:

_____ We are interested in diagnostic services **ONLY** (18 months to 21 years)

_____ We are interested in applied behavior analysis (ABA) therapy **ONLY** (18 months to 21 years)

_____ We are interested in individual and/or family therapy **ONLY** (18 months to 21 years)

_____ We are interested in **all** recommended services (18 months to 21 years)

Client Information

Date Packet Completed_____

Contact Information

Child's Name_____

Date of Birth_____ Referred by (if applicable): _____

Child's Gender: Male ___ Female ____

Address_____

City _____ State _____ Zip Code_____ County_____

Parent or Guardian 1

Name_____

Address_____

City_____ State_____ Zip_____

Relationship to Child _____

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 _____

Mobile Phone Number_____

Permission to Text: Yes No NA

Work Phone Number _____

Email _____

Parent or Guardian 2

Name_____

Address_____

City_____ State_____ Zip_____

Relationship to child _____

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 _____

Mobile Phone Number_____

Permission to Text: Yes No NA

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_____

Do you require an interpreter? ____ Yes ____ No If yes, please list language _____

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

Primary Insurance Provider _____ Policy Number _____

Group Number _____ Primary Insurance Provider Phone Number _____

Primary Insurance Provider Contract Renewal Date_____

Secondary Insurance Provider_____ Policy Number _____

Group Number _____ Secondary Insurance Provider Phone Number _____

Secondary Insurance Provider Contract Renewal Date_____

Medical Assistance-needs to be without a Health Plan or needs to be TEFRA option

Medical Assistance Number_____

Emergency Information

Emergency Contact_____ Relationship_____

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 applying with MAC?

Yes_____ No_____ If yes, how many hours per week? _____

Environmental Information:

Who currently lives in the home? _____

PARENT/GUARDIAN 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 (Please check one)		
	Mild	**Moderate**	**Severe**
Social skills, 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 your child say their 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/bladder 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 were those concerns? Did you take your child to be seen by someone and, if so, who?

EDUCATIONAL SERVICES

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

Past Educational Services	Present Educational Services
Comments	

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?

COMMUNICATION	Never	Rarely	Sometimes	Often	Always
Does your child currently speak, and can you have a conversation with him/her at their language level, where s/he builds 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 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 s/he wants something:					

RESTRICTIVE AND REPETTIVE BEHAVIORS	**N**	**R**	**S**	**O**	**A**
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.):					

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Consent for the Release of Confidential Information

I hereby give my informed consent for the following individual/entity:
Current/Past Autism Provider: _____ to release and exchange information with each other and for the Minnesota Autism Center to release and exchange information to the above named individuals and entities.

Consumer's Name (Child's Name): _____ Date of Birth: _____
Date: _____ Legal Representative (Parent/Guardian): _____

The information that may be released and exchanged includes:

Psychological Reports/Tests
Results of Observations
Diagnostic Information
Risk Management Plans
Individual Education Plans
Support Services Plans and Data
Annual and Quarterly Reports
Healthcare Information
Account Information
Discharge Report
Treatment Plans
Speech Language Pathology Records
Occupational Therapy Records

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, what will be released and exchanged, and what the information will be used for. I understand what will happen if I do or do not give my consent. I understand that the provider/facility will not condition treatment, payment, enrollment, or eligibility benefits on whether I sign this authorization. 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**

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School District and Name: _____ to release and exchange information with each other and for the Minnesota Autism Center to release and exchange information to the above named individuals and entities.

Consumer's Name (Child's Name): _____ Date of Birth: _____
Date: _____ Legal Representative (Parent/Guardian): _____

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Psychological Reports/Tests
Results of Observations
Diagnostic Information
Risk Management Plans
Individual Education Plans
Support Services Plans and Data
Annual and Quarterly Reports
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(Parent/Legal Representative)	**Date**	**(Parent/Legal Representative)**	**Date**
(Please print name)	**Date**	**(Please print name)**	**Date**