Minnesota Autism Center

Intensive Applied Behavior Analysis Therapy Programs

(18 months to 21 years)

OUR MISSION: We improve the lives of people affected by autism.
OUR VISION: That everyone dealing with autism reaches their full potential.

CHECK ANY OF THE FOLLOWING OPTIONS:

☐ We are interested in diagnostic services.
☐ Initial assessment for autism ☐ Updated assessment

☐ We are interested in applied behavior analysis (ABA) therapy.
☐ Center-based ☐ In-home ☐ Either

☐ We are interested in individual and/or family talk therapy.

PLEASE INCLUDE COPIES OF THE FOLLOWING DOCUMENTS:

(*Note that your application's review may be delayed if the following documents are not turned in with the packet. Please communicate immediately if you do not have copies of the documents)

Included:	Important Documents:
	Diagnostic assessment (previous and/or current)
	School records:
	• Individual Education Plan (IEP), if applicable
	• School evaluation, if applicable
	• Other relevant school documents

Minnesota Autism Center

Client Information

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? _____

Who currently lives in the home? _____

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 _____

Minnesota Autism Center

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

Please fill in all applicable information. If there is no insurance, please write "NA" for not applicable.

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 (*required if applicable):

Medical Assistance Number_____

Emergency Information

Emergency Contact_____ Relationship_____

Address_____ Phone _____

Service and Allied Service Providers

County Case Manager _____

Address_____ Phone _____

Has your child received Applied Behavior Analysis services previously?

Yes☐ No☐

Service Provider _____

Address_____ Phone _____

Medical Information (if applicable):

Current Diagnosis _____ Date of Diagnosis _____

Diagnosing Clinic/ Hospital _____

Diagnosing Doctor/ Examiner_____ Phone Number _____

Allergies _____

Medications _____

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	☐		☐	
Previous evaluation(s) for autism **(Please include copies)**	☐		☐	

Minnesota Autism Center

EDUCATIONAL SERVICES If your child is or has been in school, please comment on the areas below:	
Past Educational Services	Present Educational Services (please list school name):

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

PARENT/GUARDIAN QUESTIONNAIRE

Name of person completing questionnaire	
Relationship to Child:	

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:			

Please list your major concerns in the following areas, comment briefly, and rate them as indicated:	SEVERITY (Please check one)		
	Mild	Moderate	Severe
Behavior and self-regulation:			
Play skills:			
Emotional concerns:			
Self-esteem:			

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)				

Minnesota Autism Center

CHILD'S DEVELOPMENTAL HISTORY

When did your child start crawling?	Age in Months:		☐ Not yet
When did your child walk alone?	Age in Months:		☐ Not yet
When did your child say their first 5-6 words?	Age in Months:		☐ Not yet
When did your child say something that involved putting words together meaningfully (two- or three-word phrases including a verb)?	Age in Months:		☐ Not yet
When did your child potty train (urine)?	Age in Years:		☐ Not yet
When did your child potty train (bowels)?	Age in Years:		☐ Not yet
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?			

Minnesota Autism Center

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.
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 them 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 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 they wants something:					

Minnesota Autism Center

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 functionally?					
Does your child have any unusual or peculiar interests that preoccupy then 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 their napkin out flat and placing the spoon on it before eating, etc.):					
Does your child have any mannerisms or odd ways of moving their hands or fingers, or any complicated movements of their 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.):					

Understanding MAC's Introductory Trial Period:

If your child is recommended for ABA therapy, the first 30 days of service will be considered a trial period during which the center's clinical team will evaluate whether MAC's services are an appropriate fit for your child's needs. If it is deemed that MAC is not an appropriate fit for your child, MAC will make every attempt to assist you by recommending alternative service providers

Minnesota Autism Center

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**

Minnesota Autism Center

Consent for the Release of Confidential Information

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

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**

Minnesota Autism Center

Consent for the Release of Confidential Information

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

_____ _____
(Please print name) **Date**

_____ _____
(Parent/Legal Representative) **Date**

_____ _____
(Please print name) **Date**