



ENROLLMENT APPLICATION

Today's Date ____/____/____

Location _____

Please complete the following information and return to the center along with your insurance information and proof of diagnosis. Once we have received all requested information you will be contacted to set up an evaluation.

Child Information

Child's Name _____ DOB ____/____/____ Age: _____ Sex: M F

Address _____ City/State/Zip _____

Primary Diagnosis _____ Age of diagnosis? _____

Physician who gave diagnosis _____ Do you have testing results/report from this physician? YES NO

Secondary Diagnosis _____ Age of diagnosis? _____

Family Information

Mother's Name _____

Father's Name _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Home Phone _____

Home Phone _____

Cell Phone _____

Cell Phone _____

Email _____

Email _____

Child lives with (check one):

Birth Parents Foster Parents One Parent

Adoptive Parents Parent and Step-Parent Other _____

Siblings (list names and ages) _____

Is there a language other than English spoken in the home? YES NO If yes, which one? _____

Does the child speak the language? YES NO

Does the child understand the language? YES NO

Which language does the child prefer to speak at home? _____

Medical Information

Is your child on medication? YES NO

If yes, please explain what and the reason for the medication _____

Are there any medical conditions that we need to consider when delivering therapy? YES NO

If yes, please explain _____

Does your child have any allergies? YES NO Allergies: _____

Is your child on a special diet? YES NO If yes, please describe: _____

Speech-Language-Hearing

Do you feel your child has a speech problem? YES NO If yes, please describe _____

Has your child ever had a speech evaluation/screening? YES NO If yes, where? _____

Do you feel your child has a hearing problem? YES NO If yes, please describe _____

Has your child ever had a hearing evaluation/screening? YES NO If yes, where? _____

Did your child babble? YES NO Age of first words? _____ Speech and language problem first noticed at what age? _____

How much of your child's speech is understood by other adults? _____

Does your child...

- repeat sounds, words or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions ("Shut the door" or "Get your shoes")?
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions?

Your child currently communicates using:

- body language
- sign language
- PECS
- augmentative device
- sounds (vowels, grunting)
- words (shoe, doggy, up)
- 2-4 word sentences
- sentences longer than four words

Has your child ever had or are they currently receiving speech therapy? YES NO

If yes, where? _____

What was he/she working on? _____

What do you see as your child's most difficult problem in the home?

Basic Developmental Information

Please tell the approximate age your child achieved the following developmental milestones:

Sat alone _____ Babbled _____ Spoke in short sentences _____

Crawled _____ Said first words _____ Grasped crayon/pencil _____

Walked _____ Put two words together _____ Toilet trained _____

Does your child...

- choke on foods or liquids?
- currently put toys/objects in his/her mouth?
- brush/his/her teeth and/or allow brushing?

Are there any feeding issues? YES NO If yes, please explain _____

Does your child dress self completely, partially, or not at all? _____

Which hand does child use to eat? _____ to draw or write? _____ to throw a ball? _____

Therapies and Services

Please check other services that the child is *currently* receiving. Please enclose a copy of the child's most recent IEP, and/or a copy of a recent ABLLS or VB-MAPP assessment if available.

- Early Intervention Services
- Speech and/or Language Therapy
- Occupational and/or Physical Therapy
- Vision Services
- Hearing Services
- Music Therapy
- ABA/Verbal Behavior Therapy
- Aide/Paraprofessional assistance in school
- Feeding Therapy
- Other (list) _____

Behavioral Characteristics:

Please check any of the following that apply to your child:

- cooperative
- separation difficulties
- inappropriate behavior
- attentive
- easily frustrated/impulsive
- easily distracted/short attention span
- willing to try new activities
- stubborn
- destructive/throws or break objects
- plays alone appropriately
- restless/hyperactivity
- screaming/tantrums
- withdrawn
- non-compliance
- aggression towards others
- poor eye contact
- self-stimming
- self-injury

General Information

Please list things that the child seems to prefer.

Consider people, toys, activities or behaviors that s/he engages in or with on a frequent basis.

Preferred persons _____

Leisure Activities _____

Games or toys _____

Videos, music _____

Food, Snacks _____

Drinks _____

Favorite/Frequently Visited stores _____

Events _____

If left alone for a period of time, what will the child do? _____

Please describe any behavioral problems, including what you think precedes the behavior and how you respond

Goals

What are your immediate goals for your child? _____

What are your long term goals for your child? _____

The child who benefits most from an ABA program is a child whose parents are supportive of its methods and participate in its success by transferring techniques to the home environment. Are you willing to work at home with your child? YES NO

Are you able to attend parent meetings to discuss your child's progress? YES NO

Please tell us anything else that you would like us to know about your child _____

The undersigned hereby acknowledges that the information contained in this application is accurate in all respects

Parent Signature: _____ Date: _____

Notice of Nondiscriminatory Policy as to Clients

Cornerstone Autism Center does not discriminate against any person on the basis of race, color, national origin, disability, sex or age in admission, treatment, or participation in its programs, services and activities.



PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: ____/____/____ Sex: M / F

Full Address: _____

Home Phone: (____) _____ - _____

FINANCIALLY RESPONSIBLE PERSON

Name: _____ Date of Birth: ____/____/____

Full Address: _____

Home Number: (____) _____ - _____ Cell Number: (____) _____ - _____

Employer Name: _____ Employer Phone Number: (____) _____ - _____

Employer Address: _____

FIRST INSURANCE INFORMATION *(Please include a copy of the front and back of your card)*

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Date of Birth: ____/____/____ Sex: M / F

SECOND INSURANCE INFORMATION *(Please include a copy of the front and back of your card)*

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Date of Birth: ____/____/____ Sex: M / F

I authorize the release of any medical information, by Cornerstone Autism Center or its agents, in order to process medical claims with my insurance company. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I am financially responsible for payment, including any unpaid deductible, co-pay or co-insurance balances, or amounts not covered by my insurance policy.

Signature: _____ Date: _____



Behavioral Language Assessment

For the following questions in **bold**, circle the number next to the statement that best represents your child:

Child's Name _____

COOPERATION WITH ADULTS

How easy is it to work with the child?

1. Always uncooperative, avoids work, engages in negative behavior
2. Will do only one brief and easy response for a powerful reinforcer
3. Will give 5 responses without disruptive behavior
4. Will work for 5 minutes without disruptive behavior
5. Works well for 10 minutes at a table without disruptive behavior.

MOTOR IMITATION

Does the child copy the actions of others?

1. Cannot imitate anybody's motor movements
2. Imitates a few gross motor movements modeled by others
3. Imitates several gross motor movements on request
4. Imitates several fine and gross motor movements on request
5. Easily imitates any fine or gross movements, often spontaneously

VOCAL IMITATION

Will the child repeat sounds or words?

1. Cannot repeat any sounds or words
2. Will repeat a few specific sounds or words
3. Will repeat or closely approximate several sounds or words
4. Will repeat or closely approximate many different words
5. Will clearly repeat any word or even simple phrases

RECEPTIVE

Does the child understand any words or follow directions?

1. Cannot understand any words
2. Will follow a few instructions related to daily routines
3. Will follow a few instructions to do actions or touch items
4. Can follow many instructions and point to at least 25 items
5. Can point to at least 100 items, actions, persons, or adjectives

RECEPTIVE BY FUNCTION, FEATURE, AND CLASS

Does the child identify items when given information about those items?

1. Cannot identify items based on information about them
2. Will identify a few items given synonyms or common functions
3. Will identify 10 items given 1 of 3 functions or features
4. Will identify 25 items given 4 functions, features, or classes
5. Will identify 100 items given 5 functions, features, or classes

LETTERS AND NUMBERS

Does the child know any letters numbers, or written words?

1. Cannot identify any letters, numbers or written words
2. Can identify at least 3 letters or numbers
3. Can identify at least 15 letters or numbers
4. Can read at least 5 words and identify 5 numbers
5. Can read at least 25 words and identify 10 numbers

REQUESTS

How does the child let his/her needs and wants be known?

1. Cannot ask for reinforcers, or engages in negative behavior
2. Pulls people, points, or stands by reinforcing items
3. Uses 1-5 words, signs, or pictures to ask for reinforcers
4. Uses 5-10 words, signs, or pictures to ask for reinforcers
5. Frequently requests using 10 or more words, signs, or pictures

VOCAL PLAY

Does the child spontaneously say sounds and words?

1. Does not make any sounds (mute)
2. Makes a few speech sounds at a low rate
3. Vocalizes many speech sounds with varied intonations
4. Vocalizes frequently with varied intonation and says a few words
5. Vocalizes frequently and says many clearly understandable words

MATCH-TO-SAMPLE

Will the child match objects, pictures and design pictures to sample?

1. Cannot match any objects or pictures to a sample
2. Can match 1 or 2 objects or pictures to a sample
3. Can match 5 to 10 objects or pictures to a sample
4. Can match 5 to 10 colors, shapes, or designs to a sample
5. Can match most items and match 2 to 4 block designs

LABELING

Does the child label or verbally identify any items or actions?

1. Cannot identify any items or actions
2. Identifies only 1 to 5 items or actions
3. Identifies 6 to 15 items or actions
4. Identifies 16 to 50 items or actions
5. Identifies over 100 items or actions and emits short sentences

CONVERSATIONAL SKILLS

Can the child fill-in missing words or answer questions?

1. Cannot fill-in missing words or parts of songs
2. Can fill-in a few missing words or provide animal sounds
3. Can fill-in 10 non-reinforcing phrases or answer at least 10 simple questions
4. Can fill-in 20 phrases or can answer 20 questions with variation
5. Can answer at least 30 questions with variation

SOCIAL INTERACTION

Does the child initiate and sustain interactions with others?

1. Does not initiate interactions with others
2. Physically approaches others to initiate an interaction
3. Readily asks adults for reinforcers
4. Verbally interacts with peers with prompts
5. Regularly initiates and sustains verbal interactions with peers