10313 Aboite Center Road
Fort Wayne, IN 46804

Phone: (260) 459-6040
Fax: (260) 459-6010

ENROLLMENT APPLICATION

All answers provided will be confidential to staff of the Children's Autism Center, Inc., unless authorized by parents/legal guardians of child.

Date of Application: _____

Program(s) Desired
ABA/Verbal Behavior: **□ Full Time (20-30 hours/week)** **□ Part Time (10-19 hours/week)** **□ Parent Led In Home Team (time determined by parents/caregivers)**
Speech: □ Number of 30 minute sessions requested_____

Child/Client Information	
Last Name:	**Date of Birth:**
First Name:	**Gender:**
Middle Initial:	**Name preferred/Nickname:**
Home Phone:	**Grade in School:**
Address:	**School Attended:**
City:	
State: Zip:	

Mother or Legal Guardian Information	
Full Name:	**Relationship to Child, if guardian:**
Address:	
City:	**Occupation:**
State: Zip:	**Employer:**
Home Phone:	**Work Phone:**
Cell Phone:	
Email:	
Fax:	
Pager:	

Father or Legal Guardian Information	
Full Name:	**Relationship to Child, if guardian:**
Address:	
City:	**Occupation:**
State: **Zip:**	**Employer:**
Home Phone:	**Work Phone:**
Cell Phone:	
Email:	
Fax:	
Pager:	

Parents' Marital Status: □Married □Separated □Divorced □Single □Widowed
Child/client lives with: □Both parents □Mother □Father □Other_____

Child/Client's Siblings		
Name	**Age**	**Gender**

Source of Funding	**Early Intervention Medical Insurance Private Pay Medicaid Med/Autism/DD/SS Waiver Other:**			
Medical Insurance Provider				
Policy #		**Group#**	**Plan Name**	

Current Pediatrician or General Practitioner	**Physician Phone Number**
Physician Address:	
Diagnosing Dr.:	**Primary Diagnosis:** **Date of Diagnosis:**
Address:	**Phone #:**
Other condition:	**Date of Diagnosis:**

Other condition:	Date of Diagnosis:
Race (for federal regulatory purposes. CAC does not discriminate based on gender, race, or national origin) **□ White □African-American (Black) □Hispanic □Asian □Other_____**	

Medication Information

Is your child on medication? □ Yes □ No			
If yes, list medication information below:			
Medication	**Dosage**	**Time Administered**	**Purpose**

Will any of the above medication need to be administered during attendance at Children's Autism Center?
□ Yes □ No

Most Recent/Current School/Preschool	
School Name:	**Years attended:**
Address:	**Placement (typical classroom/modification, etc.):**
Phone:	
Has the child/client ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situation? □ Yes □ No If yes, please explain.	
Please summarize the hospital/treatment center's treatment and effectiveness of treatment:	
Are there any medical conditions that need to be considered when child/client is in ABA therapy or speech therapy: □ Yes □ No If yes, please explain.	

Therapies and Services

What other services are your child <u>currently</u> receiving? Include all services, including school based. Please enclose a copy of the child's most recent IEP or IFSP and Therapy goals from each area that is checked.	
Service/Therapy	**Location**
□ Verbal Behavior/ABA Services	□ School □ Home □ Other_____
□ Early Intervention Services	□ School □ Home □ Other_____
□ Speech/language therapy	□ School □ Home □ Other_____
□ Occupational Therapy	□ School □ Home □ Other _____
□ Physical Therapy	□ School □ Home □ Other_____
□ Developmental Therapy	□ School □ Home □ Other_____
□ Other_____	□ School □ Home □ Other_____
Please describe the results of these therapies in regards to success in achieving goals.	

What are your immediate goals for your child?

_____
_____
_____
_____
_____

What level of commitment are you willing to make at home in order for your child to achieve these goals?

_____
_____
_____
_____
_____

What would you like us to know about your child? Include likes and dislikes, please.

_____
_____
_____
_____
_____
_____

What, if any, behavior issues does your child have? Ex: self-injurious, aggression, lack of attention, etc., please explain.

_____
_____
_____
_____
_____
_____

Is there anything your child is fearful of? Include anything in any environment.

_____
_____
_____
_____

What current communication skills does your child have? Ex: sign language, PECS, verbal. Please explain.

_____
_____

As a member of a non-profit organization, what talents, interests, professional training, or resources would you be willing to share to CAC, if any?

_____
_____
_____

We are a non-profit organization that requires parent participation. We require each family to attend team meetings (monthly or as needed), and parent workshops so that effective teaching will continue in the home. The more parents/guardians know about Verbal Behavior and the treatment procedures here at CAC, the more the child will benefit.

Professional Crisis Management or PCM
PCM restraint procedures may be used with your child in the event of extreme behaviors that may endanger your child, other clients, staff, and/or property. Any CAC staff who will be utilizing PCM techniques is PCM trained and certified. If you have any questions or would like to see a demonstration of PCM techniques, we are happy to assist. A PCM authorization must be received by our office prior to your child's attendance at our center.

For more information on PCM, see www.pcma.com.

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

Parent/Guardian (print name)_____
Signature of Parent/Guardian):_____

Date:_____

******The following documents/items must be completed and received in order for this application to be processed.**

- q Application (enrollment form)
- q Most recent psychological exam
- q Diagnostic Report (Original diagnosis)
- q ATEC assessment
- q BLAF assessment
- q Copy front/back of insurance card
- q Check for $25.00 (non-refundable application fee)
- q PCM Authorization Signed

Please mail all the above to:
Children's Autism Center, Inc.
10313 Aboite Center Rd
Fort Wayne, IN 46804

Office use only
Date received _____ Initials _____ Incomplete? Y / N Follow up sent _____