Enrollment Application

Dear Parents/Legal Guardians,

Thank you for your interest in our center-based autism services at Partners in Excellence. Our mission is to positively impact the life of each child through our unparalleled commitment and desire to see our clients reach their greatest potential. Treatment services are aimed at developing and improving your child's communications skills, increasing social interactions with others, expressing and coping with emotions and developing self-regulation strategies.

The information you provide within this packet will be utilized to provide the treatment team with a history and background of your child's life. It is important to complete all the sections as thoroughly as you can. This is important baseline information for you so that you can have an accurate understanding of your child's current abilities as well as a basis for comparison to measure progress in treatment over time. This information will also be used to guide our assessment process to determine if Partners in Excellence is an appropriate fit for your child. Throughout the assessment process, the treatment team will assess to ensure your child will benefit from services at Partners in Excellence. Partners in Excellence reserves the right to decline services to a client and family.

Completion of this document does not guarantee enrollment into Partners in Excellence. This document must be completed and returned within 30 calendar days of your initial phone call with intake staff in order to be considered for services. Your child's file will become active once this packet and all additional required documents have been received and reviewed.

Enrollment Application

Date of Completion: **Your Name/Relationship to Child:**

Preferred Location: Choose a location **2nd Preferred Location:** Choose a location

Child's Personal Information:					
First Name	MI	Last Name	Gender ☐ Male ☒ Female	Date of Birth	Age ____years ____months
Home Address	City	State	Zip Code	County	
Mailing Address (if different)	City	State	Zip Code	County	

Parent/Guardian 1: Is parent 1 the legal guardian? ☒ Yes ☐ No				
First Name	Last Name	Relationship to Child	Home Phone	Cell Phone
Is parent 1's address the same as child's? ☐ Yes ☐ No -if no, fill in below				
Home Address	City	State	Zip Code	
Email for Parent/Guardian	Parent/Guardian /Occupation			

Parent/Guardian 2: Is parent 2 the legal guardian? ☐ Yes ☐ No				
First Name	Last Name	Relationship to Child	Home Phone	Cell Phone
Is parent 2's address the same as child's? ☐ Yes ☐ No -if no, fill in below				
Home Address	City	State	Zip Code	
Email for Parent/Guardian 1	Parent/Guardian /Occupation			

Current Living Situation:	
Child lives: ☐ home with family ☐ foster care ☐ group home ☐ other (describe) _____	
Parents are:	☐ birth parents ☐ adoptive parents ☐ other (describe) _____
Parents are:	☐ married ☐ separated ☐ divorced ☐ other (describe) _____

Primary Care Provider:			
Name	Title		
Clinic Name	Phone Number	Fax Number	
Agency Street Address	City	State	Zip Code
Date Last Seen:	Anticipated Next Visit:		

Diagnostic Information:			
What is your child's primary diagnosis?			
Date your child was first diagnosed?	Licensed Mental Health Professional/ Physician who gave diagnosis		
Agency Name	Phone Number		Fax Number
Date of Last Evaluation (include copy of evaluation)	Current ☐ yes ☐ no		Last 12 months ☐ yes ☐ no

List History of Therapies Received:

ABA Therapy:	☐ Has not previously received ABA Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (if applicable)	
Agency/ Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

Speech Therapy:	☐ Has not previously received Speech Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (if applicable)	
Agency/ Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code
☐ Yes, I would like my child to be evaluated for Speech Therapy services at Partners In Excellence ☐ No, I do not want my child to be evaluated for Speech Therapy services at Partners In Excellence			

Occupational Therapy:	☐ Has not previously received Occupational Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (if applicable)	
Agency/ Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code
☐ Yes, I would like my child to be evaluated for Occupational Therapy services at Partners In Excellence ☐ No, I do not want my child to be evaluated for Occupational Therapy services at Partners In Excellence			

Feeding Therapy:	☐ Has not previously received Feeding Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (if applicable)	
Agency/ Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code
☐ Yes, I would like my child to be evaluated for Feeding Therapy services at Partners In Excellence ☐ No, I do not want my child to be evaluated for Feeding Therapy services at Partners In Excellence			

Physical Therapy:	☐ Has not previously received Physical Therapy Services ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (if applicable)	
Agency/Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

Other:			
Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (if applicable)	
Agency/ Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

School Services:
Does your child attend preschool? ☐ yes ☐ no If yes, what is the name of the preschool?
Does your child attend school? ☐ yes ☐ no If yes, what is the name of the school and district?
If your child attends school, what is his/her educational placement? ☐ regular education ☐ special education
Does your child have an Individualized Education Plan (IEP)? ☐ yes ☐ no
Does your child have an Individualized Family Service Plan (IFSP)? ☐ yes ☐ no
If yes to either of the last two questions, when was the IEP or IFSP last updated?
Case Manager/IEP Manager's name and contact information:

Child's Race and Ethnicity:			
Check all that apply	☐ Asian ☐ African-born ☐ American Indian/Native Alaskan ☐ Black or African-American	☐ Pacific Islander/Native ☐ White ☐ Other (specify) _____ ☐ Prefer not to answer	Hispanic or Latino? ☐ yes ☐ no

Language:		
What is the primary language spoken at home?	☐ English ☐ Other (specify) _____	
Language interpreter used? ☐ yes ☐ no	If so, what language?	Sign language interpreter used? ☐ yes ☐ no

Insurance:
Is your child covered under commercial (job/employer sponsored) insurance? ☐ yes ☐ no If yes, what is the name of the commercial insurance your child is covered under? What is your child's ID number?
Does your child have state medical assistance? ☐ yes ☐ no What is your child's ID number? Minnesota: ☐ Straight MA ☐ Blue Plus ☐UCare ☐ Southwest Country ☐ Other (specify) Wisconsin: ☐BadgerCare Plus ☐Forward Health ☐Other(specify)

Check the box in each area that best describes you as a parent:				
Confidence	☐ I/we understand the diagnosis and feel competent about meeting my/our child's needs.	☐ I/we understand the diagnosis, but am/are uncertain about how to meet my/our child's needs.	☐ I/we have difficulty understanding the diagnosis and meeting my/our child's needs.	☐ I/we do/does not understand the diagnosis and do/does not know how to meet my/our child's needs.
Stress	☐ I/we experience low to moderate stress and manage it well.	☐ I/we experience times of moderate to high stress, but it is manageable.	☐ I/we have high level of stress, but usually have the capacity to cope with it.	☐ I/we have a high level of stress on a daily basis and struggle to cope with and manage the situation.
Perception of Quality of Life	☐ I/we indicate low to moderate impact of my/our child's disability on quality of life, but manage it well.	☐ I/we indicate times of moderate to high impact of my/our child's disability on quality of life, but it is manageable	☐ I/we indicate high impact of my/our child's disability on quality of life, but usually have the capacity to cope with it.	☐ I/we indicate high impact of my/our child's disability on quality of life and struggle to cope with and manage the situation.

History of Developmental Conditions or Mental Health Concerns in Other Family Members:	
Family History of: • Depression • Anxiety • Substance Abuse • Autism • Bi-polar Disorder • Schizophrenia • Learning Disabilities • Developmental Delays • Other _____	☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____ ☐ yes ☐ no If yes, whom _____

Significant Events:
Describe any child or family events which may have impacted the child's development.

Cultural Considerations
Describe any cultural considerations we should be aware of.

Family Members:
Who lives in the home? (Names, ages) Any close family that lives outside the home?

Tell us about your child:	
Initial Concerns:	
Date/Age symptoms were first noticed:	Describe symptoms:
Who noticed the symptoms:	

General Current Concerns:	
Communication:	
Social:	
Play:	
Behavioral Concerns (describe any aggressive behaviors)	
Sensory:	
Restrictive and Repetitive Behaviors	
Emotional Functioning (managing sadness, anger, anxiety):	
Personality:	
Interests:	
Strengths:	

Check the box in each domain that best describes your child:				
Social Interaction	☐ Primarily initiates and responds to social interaction in a reciprocal manner appropriate to child's age. Generally does not interfere with functioning.	☐ Some initiation and response to social interaction in a reciprocal manner appropriate to child's age depending on activity.	☐ Requires moderate levels of support to initiate and responds to others in a social manner.	☐ Needs constant 1:1 support to notice and socially initiate and respond to others.
Social Communication	☐ Primarily demonstrates integrated use of verbal and non-verbal communication appropriate to child's age. Generally does not interfere with functioning.	☐ Some abnormalities in eye contact, body language and use of gestures for purposes of communication.	☐ Moderate abnormalities in eye contact, body language and use of gestures for purposes communication.	☐ Total lack of facial expressions, body language and gestures for purpose of communication.
Restrictive, Repetitive Behaviors/Interests	☐ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input generally do not interfere with daily functioning.	☐ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause mild interference with daily functioning. Can be verbally re-directed.	☐ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause moderate interference with daily functioning. May need visual or physical re-direction.	☐ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause significant interference with daily functioning are extremely difficult to re-direct. Requires physical re-direction.
Self- Care Skills	☐ Able to perform most age-appropriate self-help skills.	☐ Requires some assistance or verbal/visual cues but performs some self-help skills independently.	☐ Requires moderate verbal, visual, and hands-on assistance for most self-help skills.	☐ Requires constant hands-on assistance for all self-help and daily cares.
Interfering or Unwanted Behaviors	☐Age-appropriate behavioral challenges in familiar and unfamiliar environments.	☐ Mild behavioral challenges in one or more familiar and unfamiliar environments.	☐ Moderate behavioral challenges across most familiar and unfamiliar environments.	☐ Severe behavioral challenges across all familiar and unfamiliar environments.
Expressive Communication	☐ Able to spontaneously verbally express ideas and needs at a level appropriate to the child's age.	☐ Some spontaneous verbal expression of simple familiar or rote phrases to communicate ideas or express needs.	☐ Limited spontaneous expression of single words/signs/gestures, and/or pictures (PECS) or other augmentative device to request items or basic needs.	☐ Child has no spontaneous functional communication strategies.

Check the box in each domain that best describes your child:				
Restrictive Communication	☐ Able to respond appropriately to familiar and unfamiliar verbal requests, at a level expected for age.	☐ Able to respond appropriately to simple familiar/rote verbal requests,but has difficulty responding to unfamiliar requests.	☐ Limited response to simple familiar requests even when paired with visual cues or gestures and is unable to respond even when paired with visual cues and gestures.	☐ Does not respond when spoken to or when words are paired with visual cues and/or gestures.
Cognitive Functioning	☐ Cognitive skills appear to be at or above age-appropriate level. No interference with age-appropriate activities and interpersonal and daily life functioning.	☐ Mild cognitive challenges present minimal interference with age-appropriate activities and interpersonal and daily life functioning.	☐ Moderate cognitive challenges interfere with age-appropriate activities and interpersonal and daily life functioning.	☐ Severe cognitive challenges interfere with all aspects of daily life including lack of age-appropriate activities and interpersonal daily- life functioning.
Safety	☐ Able to occupy self alone or with siblings safely for age-appropriate periods of time.	☐ Able to occupy self safely depending on activity,but requires moderate level of supervision for child's age.	☐ Able to occupy self safely for brief periods of times,but requires high level of supervision for child's age.	☐ Requires constant supervision to ensure safely.
Learning/Play/Motor Skills	☐ Needs no assistance in participating in age-appropriate activities.	☐ Able to participate in age-appropriate activities with minimal adult support and cues.	☐ Requires moderate level of support and cues from others needed to participate in age-appropriate activities.	☐ Requires constant support and cues from others to participate in all age-appropriate activities.
Behavior/Sensory Regulation	☐ Needs no assistance to manage sensory needs/behavior. Requires no cues or supports from others. Regulates sensory needs and behaviors independently at an age- appropriate level.	☐ Able to regulate sensory needs and behavior with minimal support or cues. Requires a few cues and support from others to regulate sensory needs and behaviors. Typically able to recognize when sensory needs or behaviors are interfering and adjust behavior.	☐ Requires moderate level of support from others to regulate sensory needs and behaviors. Requires frequent cues and supports from others to regulate sensory needs or behaviors. Often unable to recognize when sensory needs or behaviors are interfering.	☐ Requires a high level of support from others to regulate sensory needs and behaviors. Requires constant cues and supports from others to regulate sensory needs and behaviors.

Early Development:

Describe if the pregnancy was typical or atypical:

Was the pregnancy full term? ■ yes ☐ no Birth weight: ____ pounds ____ounces
If no, please describe the length of the pregnancy:

Describe if labor and delivery was typical or atypical:

Was your child hospitalized after birth and/or admitted into NICU? ☐ yes ☐ no If yes, for what and for how long:

Milestones:
Please describe when your child met communication, self-care and gross motor milestones.
Has your child ever gained skills and lost them? ☐ yes ☐ no If yes, what and for how long?:

Medical History:		
Hospitalizations	☐ yes ☐ no	If yes, please describe and provide a date:
Surgery	☐ yes ☐ no	If yes, please describe and provide a date:
Seizures	☐ yes ☐ no	If yes, please describe and provide a date:
Head Injuries/Loss of Consciousness	☐ yes ☐ no	If yes, please describe and provide a date:
High Fevers	☐ yes ☐ no	If yes, please describe and provide a date:
Other	☐ yes ☐ no	If yes, please describe and provide a date:

Prior Medical Evaluations:			
Evaluation Performed	**Date**	**By Whom**	**Reason/Result**
Well child check/annual physical			
Social Emotional screening			
Developmental screening			
Hearing			
ENT/Allergies			
Neurology			
Genetic Testing			
Other:			
Are immunizations current? ☐ yes ☐ no If no, describe reason:			

County case management services:				
Service	Yes?	Contact Name	Agency/County	Phone Number
Social Worker/Case Manager	☐			
Consumer Support Grant	☐			
Family Support Grant	☐			
DD Waiver	☐			
CADI Waiver	☐			
Other:	☐			

Emergency Plan

Client's Name:

Emergency contacts other than parents/guardians:		
Contact #1	Relation to Child	Phone Number
Contact #2	Relation to Child	Phone Number

The following people are authorized to pick up:		
Name	Relation to Child	Phone Number

The following people are restricted from contact with your child:		
Name	Relation to Child	Phone Number

Child's Physician:			
Name of Physician	Name of Clinic	Phone Number	
Address	City	State	Zip Code

Dentist:			
Name of Dentist	Name of Clinic	Phone Number	
Address	City	State	Zip Code
Transport to Which Hospital	City	Registered? ☒ yes ☐ no	Phone Number

Current Medications (include additional sheets if necessary)				
Does child take medications? ☐ yes ☐ no -If yes, list below				
Medication	**Dosage**	**Frequency**	**Reason for Use**	**Administered by Partners Staff?**
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

Allergies	
Does the child have allergies? ☐ yes ☐ no -If yes, explain type of allergy and reaction, including Medication.	
Allergy	**Reaction**

Emergency Action Plan for Seizures & Allergies:
Child has a seizure history ☒ yes ☐ no Emergency Plan: 911 will be called if: • Seizure lasts longer than5 minutes (if the seizure lasts longer than 5 minutes, 911 will be called unless a note is provided from the doctor stating otherwise) • Your child is having difficulty breathing • Vomitus is aspirated • A significant injury occurs during the seizure • Status epilepticus occurs (continuous seizure)
Describe your child's typical seizure. What do you want Partners In Excellence staff to do (other than routine First Aid) if your child has seizure while at the center?
Call Parent when:
Call Physician when: