



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:

2nd Preferred 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
First Name	Last Name	Relationship to Child	Home Phone	Cell Phone
Is parent 1's address the same as child's? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
First Name	Last Name	Relationship to Child	Home Phone	Cell Phone
Is parent 2's address the same as child's? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> home with family <input type="checkbox"/> foster care <input type="checkbox"/> group home <input type="checkbox"/> other (describe) _____
Parents are:	<input type="checkbox"/> birth parents <input type="checkbox"/> adoptive parents <input type="checkbox"/> other (describe) _____
Parents are:	<input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> 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:			
<input type="checkbox"/> Has not previously received Feeding Therapy <input type="checkbox"/> Previously received services (List below) <input type="checkbox"/> 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
<input type="checkbox"/> Yes, I would like my child to be evaluated for Feeding Therapy services at Partners In Excellence <input type="checkbox"/> No, I do not want my child to be evaluated for Feeding Therapy services at Partners In Excellence			

Physical Therapy:			
<input type="checkbox"/> Has not previously received Physical Therapy Services <input type="checkbox"/> Previously received services (List below) <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, what is the name of the preschool?	
Does your child attend school? <input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, what is the name of the school and district?	
If your child attends school, what is his/her educational placement? <input type="checkbox"/> regular education <input type="checkbox"/> special education	
Does your child have an Individualized Education Plan (IEP)? <input type="checkbox"/> yes <input type="checkbox"/> no	
Does your child have an Individualized Family Service Plan (IFSP)? <input type="checkbox"/> yes <input type="checkbox"/> 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	<input type="checkbox"/> Asian <input type="checkbox"/> African-born <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Black or African-American	<input type="checkbox"/> Pacific Islander/Native <input type="checkbox"/> White <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Prefer not to answer
	Hispanic or Latino?	
		<input type="checkbox"/> yes <input type="checkbox"/> no

Language:		
What is the primary language spoken at home?	<input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____	
Language interpreter used? <input type="checkbox"/> yes <input type="checkbox"/> no	If so, what language?	Sign language interpreter used? yes no

Insurance:			
Is your child covered under commercial (job/employer sponsored) insurance?	Yes	No	In the process of applying for medical assistance/TEFRA
If yes, what is the name of the commercial insurance your child is covered under?			
What is your child's ID number?	Subscriber's first and last name:		Subscriber DOB:
Does your child have state medical assistance? <input type="checkbox"/> yes <input type="checkbox"/> no			
What is your child's ID number?			
Minnesota: <input type="checkbox"/> Straight MA <input type="checkbox"/> Blue Plus <input type="checkbox"/> UCare <input type="checkbox"/> Southwest Country <input type="checkbox"/> Other (specify)			
Wisconsin: <input type="checkbox"/> BadgerCare Plus <input type="checkbox"/> Forward Health <input type="checkbox"/> Other(specify)			

Check the box in each area that best describes you as a parent:				
Confidence	<input type="checkbox"/> I/we understand the diagnosis and feel competent about meeting my/our child's needs.	<input type="checkbox"/> I/we understand the diagnosis, but am/are uncertain about how to meet my/our child's needs.	<input type="checkbox"/> I/we have difficulty understanding the diagnosis and meeting my/our child's needs.	<input type="checkbox"/> I/we do/does not understand the diagnosis and do/does not know how to meet my/our child's needs.
Stress	<input type="checkbox"/> I/we experience low to moderate stress and manage it well.	<input type="checkbox"/> I/we experience times of moderate to high stress, but it is manageable.	<input type="checkbox"/> I/we have high level of stress, but usually have the capacity to cope with it.	<input type="checkbox"/> 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	<input type="checkbox"/> I/we indicate low to moderate impact of my/our child's disability on quality of life, but manage it well.	<input type="checkbox"/> I/we indicate times of moderate to high impact of my/our child's disability on quality of life, but it is manageable	<input type="checkbox"/> I/we indicate high impact of my/our child's disability on quality of life, but usually have the capacity to cope with it.	<input type="checkbox"/> 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	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Substance Abuse	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Autism	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Bi-polar Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Schizophrenia	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Learning Disabilities	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Developmental Delays	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, whom _____
• Other _____	<input type="checkbox"/> yes <input type="checkbox"/> 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	<input type="checkbox"/> Primarily initiates and responds to social interaction in a reciprocal manner appropriate to child's age. Generally does not interfere with functioning.	<input type="checkbox"/> Some initiation and response to social interaction in a reciprocal manner appropriate to child's age depending on activity.	<input type="checkbox"/> Requires moderate levels of support to initiate and responds to others in a social manner.	<input type="checkbox"/> Needs constant 1:1 support to notice and socially initiate and respond to others.
Social Communication	<input type="checkbox"/> Primarily demonstrates integrated use of verbal and non-verbal communication appropriate to child's age. Generally does not interfere with functioning.	<input type="checkbox"/> Some abnormalities in eye contact, body language and use of gestures for purposes of communication.	<input type="checkbox"/> Moderate abnormalities in eye contact, body language and use of gestures for purposes of communication.	<input type="checkbox"/> Total lack of facial expressions, body language and gestures for purpose of communication.
Restrictive, Repetitive Behaviors/Interests	<input type="checkbox"/> Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input generally do not interfere with daily functioning.	<input type="checkbox"/> Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause mild interference with daily functioning. Can be verbally re-directed.	<input type="checkbox"/> Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause moderate interference with daily functioning. May need visual or physical re-direction.	<input type="checkbox"/> 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	<input type="checkbox"/> Able to perform most age-appropriate self-help skills.	<input type="checkbox"/> Requires some assistance or verbal/visual cues but performs some self-help skills independently.	<input type="checkbox"/> Requires moderate verbal, visual, and hands-on assistance for most self-help skills.	<input type="checkbox"/> Requires constant hands-on assistance for all self-help and daily cares.
Interfering or Unwanted Behaviors	<input type="checkbox"/> Age-appropriate behavioral challenges in familiar and unfamiliar environments.	<input type="checkbox"/> Mild behavioral challenges in one or more familiar and unfamiliar environments.	<input type="checkbox"/> Moderate behavioral challenges across most familiar and unfamiliar environments.	<input type="checkbox"/> Severe behavioral challenges across all familiar and unfamiliar environments.
Expressive Communication	<input type="checkbox"/> Able to spontaneously verbally express ideas and needs at a level appropriate to the child's age.	<input type="checkbox"/> Some spontaneous verbal expression of simple familiar or rote phrases to communicate ideas or express needs.	<input type="checkbox"/> Limited spontaneous expression of single words/signs/gestures, and/or pictures (PECS) or other augmentative device to request items or basic needs.	<input type="checkbox"/> Child has no spontaneous functional communication strategies.

Check the box in each domain that best describes your child:				
Restrictive Communication	<input type="checkbox"/> Able to respond appropriately to familiar and unfamiliar verbal requests, at a level expected for age.	<input type="checkbox"/> Able to respond appropriately to simple familiar/rote verbal requests, but has difficulty responding to unfamiliar requests.	<input type="checkbox"/> 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.	<input type="checkbox"/> Does not respond when spoken to or when words are paired with visual cues and/or gestures.
Cognitive Functioning	<input type="checkbox"/> Cognitive skills appear to be at or above age-appropriate level. No interference with age-appropriate activities and interpersonal and daily life functioning.	<input type="checkbox"/> Mild cognitive challenges present minimal interference with age-appropriate activities and interpersonal and daily life functioning.	<input type="checkbox"/> Moderate cognitive challenges interfere with age-appropriate activities and interpersonal and daily life functioning.	<input type="checkbox"/> Severe cognitive challenges interfere with all aspects of daily life including lack of age-appropriate activities and interpersonal daily-life functioning.
Safety	<input type="checkbox"/> Able to occupy self alone or with siblings safely for age-appropriate periods of time.	<input type="checkbox"/> Able to occupy self safely depending on activity, but requires moderate level of supervision for child's age.	<input type="checkbox"/> Able to occupy self safely for brief periods of times, but requires high level of supervision for child's age.	<input type="checkbox"/> Requires constant supervision to ensure safely.
Learning/Play/Motor Skills	<input type="checkbox"/> Needs no assistance in participating in age-appropriate activities.	<input type="checkbox"/> Able to participate in age-appropriate activities with minimal adult support and cues.	<input type="checkbox"/> Requires moderate level of support and cues from others needed to participate in age-appropriate activities.	<input type="checkbox"/> Requires constant support and cues from others to participate in all age-appropriate activities.
Behavior/Sensory Regulation	<input type="checkbox"/> 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.	<input type="checkbox"/> 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.	<input type="checkbox"/> 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.	<input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> 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?	Phone Number
		<input type="checkbox"/> yes <input type="checkbox"/> no	

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?
				<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> yes <input type="checkbox"/> no

AllergiesDoes 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 than 5 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: