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: Arden Hills **2nd Preferred Location:** Arden Hills

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)
Agency/ Clinic Name	City

Speech Therapy:	☐ Has not previously received Speech therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)
Agency/ Clinic Name	City

Occupational Therapy:	☐ Has not previously received Occupational Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)
Agency/ Clinic Name	City

Feeding Therapy:	☐ Has not previously received Feeding Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)
Agency/ Clinic Name	City

Physical Therapy:	☐ Has not previously received Physical therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)
Agency/Clinic Name	City

Other:	
Agency/Clinic Name	City

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 your preferred spoken language? ☐ English ☐ Other (specify): _____		
Language interpreter used? ☐ yes ☐ no	If so, what language?	Sign language interpreter used? ☐ yes ☐ no
What is your preferred written language? ☐ English ☐ Other (specify): _____		
What is the parent/caregiver's level of literacy (i.e., ability to read and/or write)? ☐ Cannot read/write ☐ Reads/writes at elementary level ☐ Reads/writes at high school/secondary level ☐ Reads/writes at college level		

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? ☐ yes ☐ no What is your child's ID number? Minnesota: ☐ Straight MA ☐ Blue Plus ☐ UCare ☐ Southwest County ☐ Other (specify): _____ Wisconsin: ☐ BadgerCare Plus ☐ Forward Health ☐ Other (specify): _____