**Application for Services**

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| --- | --- | --- | --- | --- | --- |
| Name of Person Completing Form: | | | | | Date: / / |
| **Applicant Information** | | | | | |
| Name of Client: | | | | | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
| Date of Birth: / / | Ethnicity: | | | | Gender: |
|  |  | | | |  |
| **Parent/Guardian Information** | | | | | |
| Parent/Guardian Name: | | | | Relationship to Client: | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
| Home Phone Number: ( ) | | Cell Phone Number: ( ) | | | |
| Email Address: | | | | | |
| Parent/Guardian Name: | | | | Relationship to Client: | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
| Home Phone Number: ( ) | | Cell Phone Number: ( ) | | | |
| Email Address: | | | | | |
|  | | | | | |
| **Referral Source** | | | | | |
| How did you hear about our services? | | | | | |
| Referring Agency Name: | | | | | |
| Contact Person Name: | | | | Phone Number: ( ) | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
| Support Coordinator Name: | | | | Phone Number: ( ) | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
|  | | | | | |
| **Family Information** | | | | | |
| Primary Language Spoken at Home: | | Primary Language Spoken by Client: | | | |
| Primary Form of Communication: | | | | | |
| Does the client have any siblings? | | | | | |
| If so, what are their names and ages? | | | | | |
| Are there other people living in the home (family friends, extended family, etc.)? | | | | | |
| Family Income Range: (please check)  <$24,999 $25,000-49,999 $50,000-74,999 $75,000-99,999 $100,000+ | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **Educational History** | | | | | |
| Day program/school/EI program name: | | | | | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
| Phone Number: ( ) | | | | | |
| Class Type (please check):  Self-contained Inclusion  Regular  Home-based Instruction  Home Schooled | | | | | |
| Grade: | | Date of Last IEP/IFSP: / / | | | |
|  | | | | | |
| **Medical History** | | | | | |
| Diagnosis: | | | | | |
| When was the client diagnosed (date/age)? | | | | | |
| Who made the diagnosis (name/title)? | | | | Phone Number: ( ) | |
| *Please forward a copy of the diagnostic report to the program.* | | | | | |
|  | | | | | |
| Primary Physician: | | | | Phone Number: ( ) | |
| Address: | | | | | |
| City: | | | State: | | Zip: |
| *Please forward a copy of the most recent physical examination and up-to-date immunization record.* | | | | | |
|  | | | | | |
| Speech Therapist: | | | | Phone Number: ( ) | |
| Occupational Therapist: | | | | Phone Number: ( ) | |
| In-Home Supports: | | | | Phone Number: ( ) | |
| Psychiatrist: | | | | Phone Number: ( ) | |
| Developmental Pediatrician: | | | | Phone Number: ( ) | |
| Other Therapy (name/type): | | | | Phone Number: ( ) | |
| Does the client have any medical concerns? | | | | | |
| Does the client take medication regularly? If yes, please list the name, dosage, and times for all given medications: | | | | | |
| Does the client have a history of seizures? | | | | | |
| Does the client have any allergies? If yes, please list: | | | | | |
| Does the client have any physical disabilities? If yes, please list: | | | | | |
| **Behavioral History** | | | | |
| Does the client have any specific eating problems or mealtime behaviors? | | | | |
| Is the client toilet-trained? | | | | |
| Does the client have difficulty sleeping or other bedtime issues? | | | | |
| Does the client display any of the following behavior (please circle):  Aggression Self-Injury Non-Compliance Destruction Inflexible Routines or Rituals Stereotypy(self-stimulatory behavior) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please describe what these behaviors look like for the client and how you respond: | | | | |

Is there anything else you would like us to know about the client?

**FOR OFFICE USE ONLY:**

Date Application Received: Received by:

Date of First Appointment: Therapist Assigned:

Notes: