Sunshine Academy
ABA Therapy

Enrollment Application

Please fill out this packet in full. Once we receive this packet and all required documents, we will call and schedule a tour/consult. Filling out this packet does not guarantee your child admissions. A consult will be done by a BCBA to determine if your child is a fit for our center based on their needs.

Child Information

Child's Name		**Date of Birth**	
Street Address		**Age**	
City, State, Zip		**Sex**	**M F**
Child's Height			

Autism Diagnosis?	**Yes No**	**Age of Diagnosis**	
Diagnosing Physician		**Date of Diagnosis**	
Other Diagnoses			
Referring Physician for ABA Assessment/ Treatment			
Does your child have a current psychological evaluation?		**Yes No**	
Completed by			
Date of last psychological evaluation			

Insurance Information

Plan		**Insured's Name**	
ID Number		**Insured's Date of Birth**	
Group Number		**Relationship to Client**	

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Family Information

	Mother	Father
Name		
Address		
Phone		
Email		
Custody	Full Joint None	Full Joint None
Who lives in the primary home?		
Primary language spoken at home		

Medical Information

Does your child:	**Yes**	**No**	**If yes, please list:**
Take medication?			
Have medical conditions?			
Have allergies?			
Follow a special diet?			
Does your child:	**Yes**	**No**	**If yes, please list provider:**
Receive Speech services?			
Receive OT services?			
Receive PT services?			
Other services?			

Developmental Information

Does your child:	**Yes**	**No**	**If yes, please explain:**
Have feeding concerns?			
Need help with dressing?			
Need help with bathing or other self-care tasks?			
Is your child toilet trained?			

Speech, Language and Hearing

Does your child:	Yes	No	If yes, please describe:
Have a speech delay?			
Have a hearing deficit?			
Use a picture exchange system or assistive communication device?			

How does your child typically communicate?	Grunts, screams, whines	Points / gestures / eye contact	Pulls / leads others	Uses 1-2 words	Speaks in sentences
To get your attention					
To request something					
To refuse / protest					
To greet others					

Does your child:	Yes	No	Comments
Imitate others?			
Follow simple directions most of the time?			
Respond correctly to yes/no questions?			
Respond correctly to simple questions?			
Participate in back and forth conversations?			
Play with age-appropriate toys?			
Show interest in other children?			

School History

Does your child:	Yes	No	Comments
Attend school?			Part-time Full-time Home-schooled Total hours in school:
Participate in a general education classroom?			Number of hours:
Participate in a special education classroom?			Number of hours:
Have an IEP or 504 plan?			If yes, please attach a copy.

Challenging Behaviors

Is this behavior a concern?	Yes	No	If yes, please describe:
Elopement (running)			
Tantrums			
Property damage			
Self-injury			
Physical aggression			
Verbal aggression			
Repetitive behaviors			
Other:			

Preferences (please list)

Preferred Items	
Preferred Activities	
Preferred People	
Preferred Foods	

Goals of ABA Therapy – Choose 3

Please select your top 3 goals you would like your child to achieve through ABA therapy:

	Improve ability to communicate wants and needs
	Improve social skills with peers
	Improve cooperation with requests from others
	Increase self-care skills (bathing, toileting, tooth-brushing, etc)
	Improve focus and task completion
	Improve toleration of changes
	Improve play skills
	Increase school-readiness skills
	Improve behavior during transitions
	Toilet-training
	Decrease meltdowns/tantrum behavior
	Decrease repetitive behaviors
	Decrease elopement
	Decrease self-injurious behavior
	Decrease aggressive behavior
	Decrease food selectivity/refusal
	Other:

Active Participation in Services

Are you willing to:	**Yes**	**No**
Ensure your child's guaranteed attendance at multiple weekly ABA sessions totaling a minimum of 20 hours per week? *		
Attend parent trainings 1-2 times per Month?		
Implement treatment plan to the best of your ability?		
Make environmental modifications at home as recommended?		

* Hours are based on BCBA recommendations following the initial assessment and insurance approval.

Potential Barriers

Potential Barriers	Yes	No	Please provide details (e.g., days/times affected)
Does your child attend other therapies at clinics other than Sunshine Center?			
Are you willing to re-schedule other ST OT therapies or transition to Sunshine Center if needed to fit your child's ABA schedule?			
Does your child attend school/ pre-school?			
Are you willing to do school pull-out if recommended?			
Will caregiver work schedule or transportation be a barrier to bringing your child to therapy?			
Are there other barriers that may affect your child's availability?			

Sunshine Academy
Behavioral Therapy

Sunshine Center
Pediatric Therapy

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ Date of Birth: _____

I request and authorize **Tulsa Sunshine Center** and **Sunshine Academy** to share healthcare information of the client named above.

This request of authorization to release information applies to healthcare information relating to Speech-Language Therapy, Occupational therapy, and/or ABA therapy.

I further release Tulsa Sunshine Center and Sunshine Academy from the responsibility of any effect the release of my child's clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and hold Tulsa Sunshine Center blameless for conclusions or opinions drawn without professional knowledge, assistance, or review.

By state law, you must be advised that: The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Date Signed: _____ Relationship to Client: _____

ACKNOWLEDGEMENT

I acknowledge that all information contained in this application is accurate.

_____ _____

Parent Signature Date

_____ _____

Reviewer Signature Date

****Required documentation to be submitted with Application****

- Autism Spectrum Disorder diagnosis p a p e r w o r k (ASD) from a Pediatric Neurologist or Neurologist, Developmental Pediatrician, Licensed Psychologist, Psychiatrist or Neuropsychiatrist
- Copy of Medical Insurance Card
- Copy of Drives License of Insurance Policy Holder
- Prescription/Referral for ABA services (stating ABA assessment and ABA treatment) from referring physician