902 Spaulding Street,
San Angelo, Texas, 325-617-5845

The ABC Center is comprised of high-quality professionals who are experienced with children with autism and other disabilities. Our Board Certified Behavior Analyst (BCBA) and Board Certified Assistant Behavior Analyst (BCaBA) provide direct Applied Behavior Analysis (ABA) services to children through direct, one-on-one services. Training of family and educators may also be provided to ensure that our children continue to progress in their homes, schools, and in the community. The Speech and Language Pathologist aids in the facilitation of language processing, understanding of temporal, spatial, and relational concepts, and improving articulation in specific speech related disorders. We believe that every child has the potential to learn. The team focuses on the increase of communication, learning, and appropriate social behavior as well as the reduction of inappropriate behaviors.

My priority for treatment:

- ☐ **Decreasing inappropriate behavior**
- ☐ **Teaching language**
- ☐ **Teaching new skills**
- ☐ **Other _____**

IDENTIFYING INFORMATION:

NAME: _____ D.O.B: _____ Age: _____

Sex: ____ County of residence: _____

Height: _____ Feet. _____ Inches. Weight. _____ Lbs.

Please list all diagnoses: _____

_____

Age of diagnoses and diagnosing doctor:_____

Current Address

_____

_____

_____

Phone: _____

E-mail:_____

Name & Address of Primary Correspondent

_____

_____

_____

Phone: _____

E-mail:_____

Service Coordinator: Name: _____ Affiliation: _____

Phone Number: _____ email: _____

Current Day Treatment Program/ School/Day Care:

_____

Current Pediatrician name and phone number: _____

Who has previously provided any behavioral consultation/services? _____

Other therapies/professional services currently attending/receiving:_____

_____

Admission Criteria for Services

1) **Age:** date of diagnosis– 18 years. Each child must have a legally authorized representative for consent purposes (example: parent, guardian, or managing conservator).
2) **Diagnoses:** A diagnosis of Autism Spectrum Disorder, or diagnosis of a Pervasive Developmental Disorder (i.e. Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, or Pervasive Developmental Disorder-Not Otherwise Specified) and Other disabilities resulting in social, communicative, or behavioral challenges.
3) **Family Involvement:** Family may be asked to make a time commitment to learn and practice specific skills necessary for the child's behavior to continue improving.
4) **Payment:** Based on current rates of service, private insurance coverage, and responsible parties.

Family Situation: (Provide information such as living situation, education, employment, health, marital status, and relationship with applicant, etc.).
Mother:

_____
_____
_____
_____

Father:

_____
_____
_____
_____

Siblings:

_____
_____
_____
_____

Briefly describe what is currently happening. Why do you want the services?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DIAGNOSTIC INFORMATION:

Does the individual have any of the following? (Check all that apply).

	Yes	No	Don't Know	Describe
Seizures	☐	☐	☐	
Visual Impairment	☐	☐	☐	
Hearing Problems	☐	☐	☐	
Other Impairment (describe)	☐	☐	☐	

Medications:

Current Medications	Dosage	Reason Prescribed

Special Diet? Allergies? Describe:_____

MEDICAL HISTORY:

Problems during pregnancy?_____

Problems at birth? _____ Full term?_____

What age did the child:

	Months of age
Crawl	
Walk	
Speak first words	
Speak in 2-3 word phrases	
Ask questions	
Point to items	

Was there a regression?_____ If yes, when? _____ Skills lost:_____

Other therapies attended or currently attending, when?: _____

Location: _____

BEHAVIOR STATUS: **How often did the behavior occur?**

	Number of times per…	Hour	Day	Week
Physical Aggression		☐	☐	☐
Verbal Aggression		☐	☐	☐
Property Destruction		☐	☐	☐
Non-Compliance		☐	☐	☐
Injury to Self		☐	☐	☐
Injury to Others		☐	☐	☐
Unauthorized Departure		☐	☐	☐
Pica (ingestion of inedible substance)		☐	☐	☐
Theft		☐	☐	☐
Inappropriate Sexual Behavior		☐	☐	☐
Non-cooperative with eating		☐	☐	☐
Other (explain)_____		☐	☐	☐

ADAPTIVE BEHAVIOR:

Please tell us about his/her Level of Independence:

Self-Help Skill	Independent	Verbal Prompts	Physical Assistance
Toileting			
Dressing			
Eating			
Bathing			
Grooming			
Self Administration of Medication			

Please check the appropriate box:

Communication: ☐ Verbal ☐ Non-Verbal ☐ Sign Language ☐ PECs/pictures
☐ Other _____

Movement: ☐ Walks ☐ Doesn't Walk independently ☐ Crawls ☐ Other _____

Please enclose the following:

1) Determination of all Diagnoses
2) Current IEP and ARD deliberations (if currently in school)
3) Copy of insurance card front and back (if you are planning on filing for insurance)

Signature of Parent:_____ Date:_____

Please submit this application as follows

BY MAIL: ABC Center for Children ***C/O: Greg Rowe, MHMRCV*** 1501 West Beauregard Avenue San Angelo, Texas 76901
IN PERSON: ABC Center for Children 902 Spaulding Street San Angelo, Texas 76903
BY EMAIL: Save form to your computer FIRST—then attach the SAVED form and e-mail by clicking on the link below: abc@mhmrcv.org