ADAPTIVE SKILL BUILDING

Application

If you need assistance completing this application, call the ASB Program: 1-800-270-1861.

Please provide contact and demographic information for the child:

Child's Name:

_____ _____ _____
Last Middle First

Child's DOB: _____/_____/_____ Child's Current Age: _____

Child's SSN: _____-_____-_____ Child's Gender: ____Male ____Female

Child's Ethnic Background: (select one) ___ Hispanic ___ Non-Hispanic

Child's Race: (select as many as apply)

___ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South American, including Central America, and who maintains tribal affiliation or community attachment
___ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
___ Black/African American	A person having origins in any of the black racial groups of Africa.
___ Native Hawaiian/Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
___ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please provide information about the child's current custody status:

___ Child's biological parents, as a family unit, maintain full physical and legal custody.

___ Child is legally adopted, and both adoptive parents maintain full physical and legal custody.

___ Child's mother maintains full/sole physical and legal custody.

___ Child's father maintains full/sole physical and legal custody.

___ Child's parents maintain joint /shared physical and legal custody.

___ Child's parents have an arrangement not indicated above, or custody is being disputed.

___ Child is in CYFD custody.

Note: If you selected an option other than the first or second, a copy of paperwork relevant to the custody arrangement must be provided. If legal custody is shared, both parents must consent to intervention services.

Please provide contact information for the child's primary parent/guardian :

For the purposes of this application, "primary" refers to the person who has primary custody/ guardianship, or the person who is best able to answer questions about the child.

Name: _____

Relationship to child: (e.g., biological mother) _____

Address: _____

Phone:

Home (_____) _____ Okay to leave message? ___Yes ___ No

Cell (_____) _____ Okay to leave message? ___Yes ___ No

Work (_____) _____ Okay to leave message? ___Yes ___ No

Email 1:_____ Okay to send message? ___Yes ___ No

Email 1:_____ Okay to send message? ___Yes ___ No

(Note: Messages sent via email will be encrypted to protect your child's health information.)

Is the child's primary residence with the primary parent/guardian? ___Yes ___ No

If no, please explain: _____

_____

Please provide contact information for the child's other parent/guardian, if applicable:

For the purposes of this application, "other parent/guardian" refers to the person who shares custody/ guardianship with the primary parent/guardian indicated above.

Name: _____

Relationship to child: (e.g., biological father) _____

Address: _____

Phone:

Home (_____) _____ Okay to leave message? ___Yes ___ No

Cell (_____) _____ Okay to leave message? ___Yes ___ No

Work (_____) _____ Okay to leave message? ___Yes ___ No

Email 1:_____ Okay to send message? ___Yes ___ No

Email 1:_____ Okay to send message? ___Yes ___ No

Please provide information about the child's current home environment:

Who resides at home with the child? (First names are sufficient.)

Name:_____ Age: _____ Relationship to child:_____

Name:_____ Age: _____ Relationship to child:_____

Name:_____ Age: _____ Relationship to child:_____

Name:_____ Age: _____ Relationship to child:_____

Name:_____ Age: _____ Relationship to child:_____

Name:_____ Age: _____ Relationship to child:_____

Who will be involved in the child's ASB intervention? In other words, which adult(s) will be present during sessions? Who will learn the strategies and techniques that will best support the child's ongoing success? (Note: At least one adult must be committed to being actively involved in the intervention program. This may be someone who lives with the child, such as the child's mother or father, and/or it may be someone who lives outside of the home but cares for the child, such as a grandparent or other close relative.)

_____

Does the family have any religious or cultural values to which in-home service providers should be sensitive? If so, please describe here and plan to discuss further once services are initiated:

_____

_____

_____

_____

Is there any foreseeable reason that it would be unsafe or uncomfortable for a service provider to provide intervention services in the home? (For example: significant marital discord or abuse, immediate family member involved in ongoing legal matter, high-crime/dangerous area, etc.): ___ Yes ___ No

If yes, please describe: _____

_____

_____

If yes, are there community settings that may be a good alternative to providing services in the home, if necessary (e.g., a local park, an after-school center, a church/synagogue, etc.):

_____

_____

_____

Given that intervention services are rendered at home, and some staff may have allergies, please note what pets live indoors, if any: ___ Cat(s) ___ Dog(s) ___ Other: _____

Given that intervention services are rendered at home, and some staff may have allergies, please note if residents or guests smoke in the home: ___ Non-smoking residence ___ Smoking residence

Please provide any other information about the child's home that may be helpful in planning in-home intervention services (e.g., areas that are ideal for working with child, areas that are off-limits, parking information, etc.):

_____

_____

_____

_____

Please provide information about the child and family's language and communication:

Which of the following statements best describes the child's language and communication level? If none of the statements fit the child, please provide a brief description.

___ Child is best described as "nonverbal" (although he/she may make some sounds and word approximations). The child does not have a good way to get his/her needs met.

___ Child is best described as "nonverbal " (although he/she may make some sounds and word approximations). However, the child has a functional communication system (PECS, sign language, augmentative communication device, etc.), and therefore the child is able to get his/her needs met.

___ Child is verbal, but verbal skills are limited to single words or short phrases. The child may use another system to support communication but he/she primarily speaks to communicate his/her wants and needs.

___ Child is quite verbal (uses full sentence, functional speech) and uses a variety of appropriate nonverbal communicative strategies too (e.g., gestures such as pointing, waving, clapping, etc.).

___ Other: _____

_____

_____

_____

If the child uses an alternative communication system, or has a system to support his/her spoken language, please indicate what it is (e.g., PECS, sign language, an augmentative device), and please indicate how skillful he/she is at using the system:

_____

_____

If the child is verbal, what language is spoken by the child? _____

What is the primary language spoken by the child's family? _____

Is a second language spoken in the home? ___ No ___ Yes:_____

What language(s) does the family use when speaking to the child?_____

Please provide information about the child's Autism Spectrum Disorder diagnosis:

For entry into the ASB program, the child must have a confirmed *medical* diagnosis of Autism. (Note: An educational evaluation by the child's school is not sufficient.) If using DSM-IV-TR criteria, this includes Autistic Disorder, Asperger's Disorder, or Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS). If using DSM-5 criteria, this includes Autism Spectrum Disorder.

How old was the child when he/she was first diagnosed with Autism Spectrum Disorder? _____

Who provided the child with his/her first Autism Spectrum Disorder diagnosis? _____

_____

What diagnosis was the child given?

___ Autistic Disorder ___ Asperger's Disorder

___ PDD-NOS ___ Autism Spectrum Disorder (applicable if recently diagnosed using DSM-5)

Has the child been re-evaluated since his/her first evaluation? ___ Yes ___ No

If yes, please indicate when the child was evaluated, by whom, and what diagnosis was given:

When:___/___/___ Who: _____

Diagnosis: _____

When:___/___/___ Who: _____

Diagnosis: _____

When:___/___/___ Who: _____

Diagnosis: _____

Does the child know that they have an Autism Spectrum Disorder? ___ Yes ___ No

If no, please indicate why:

___ Family prefers that the child not know his/her diagnosis at this time.

___ Child is too young, or does not have the skills to support an understanding of the diagnosis.

___ Other: _____

(Please provide a copy of all diagnostic evaluation reports.)

Please provide information about the child's school and educational supports:

Where does child receive education? ___ Public school ___ Private school ___Home ___ Online

Name of school: _____ Current grade: _____

Name of the person at school who knows the child best, if applicable: _____

What is this person's relationship to the child? _____

On a scale of 1 to 10, with 10 being the best, how well has the child done at school recently (i.e., during the last 2-3 months)?

1 (Very poorly) 2 3 4 5 6 7 8 9 10 (Very good)

Does the child receive special education services? ___ Yes ___ No

If no, please indicate why not:

___ Never requested ___ Waiting for evaluation

___ Denied eligibility ___ Received previously, but not now

If yes, please answer the following questions:

When was the child last evaluated by his/her school? _____

When was the child's IEP last updated? _____

What is the child's primary exceptionality? _____

What is the child's secondary exceptionality? _____

Does the child have a current Behavior Intervention Plan? ___ Yes ___ No

(Please provide a copy of the child's most recent educational testing, as well as a copy of the child's current IEP and BIP, if applicable.)

Please provide information about community outings:

On a scale of 1 to 10, with 10 being the best, how successful are parents/guardians in bringing the child into the community (i.e., grocery store, park, restaurant, etc.)?

1 (Very poorly) 2 3 4 5 6 7 8 9 10 (Very good)

Please briefly describe difficulties that are experienced during community outings, if applicable:

_____

_____

_____

Please provide information about the child's primary health care providers and health status:

Does the child see a medical doctor for regular check-ups or when sick? ___ Yes ___ No

If yes, who is the child's Primary Care Physician (PCP)? _____

With which hospital/clinic is this doctor affiliated? _____

Other than the child's ASD diagnosis, what medical diagnoses, if any, has the child received (e.g., seizure disorder, seasonal allergies, diabetes)?

_____

_____

_____

Does the child see his/her doctor or a psychiatrist for medication management? ___ Yes ___ No

If yes, who manages the child's medications? _____

What medications does the child currently take? Please note the medication name and dosage:

_____

_____

_____

_____

Does the child have any known food or environmental allergies? ___ Yes ___ No

If yes, please indicate: _____

_____

Is the child on a special diet? ___ Yes ___ No

If yes, please describe: _____

_____

Does the child see a dentist for regular check-ups or when problems occur? ___ Yes ___ No

If yes, who is the child's dentist? _____

If the child receives other *medical* health care services (e.g., from a gastroenterologist, sleep doctor, allergist, etc.), please indicate the provider(s) and nature of the service(s):

_____

_____

_____

(It is *not* necessary to provide a copy of general health/medical records with this application. If medical records are needed then they will be requested at a later date.)

Please provide information about the child's madapative/problem behavior:

Does the child engage in behavior that you would like to see reduced or eliminated? ___ Yes ___ No

If "yes," select the behavior(s), offer a description, and indicate the frequency and level of concern:

___ Self-injury (hurting him/herself): _____

_____

_____

How frequent: ___ Hourly ___ Daily ___ Weekly ___ Monthly ___ Yearly

How concerned: ___ Not concerned ___ Somewhat concerned ___ Very concerned

___ Aggression (hurting other people or animals):_____

_____

_____

How frequent: ___ Hourly ___ Daily ___ Weekly ___ Monthly ___ Yearly

How concerned: ___ Not concerned ___ Somewhat concerned ___ Very concerned

___ Disruptive behavior (throwing or breaking things, spitting, yelling, etc.):_____

_____

_____

How frequent: ___ Hourly ___ Daily ___ Weekly ___ Monthly ___ Yearly

How concerned: ___ Not concerned ___ Somewhat concerned ___ Very concerned

___ Pica (eating non-edible items) : _____

_____

_____

How frequent: ___ Hourly ___ Daily ___ Weekly ___ Monthly ___ Yearly

How concerned: ___ Not concerned ___ Somewhat concerned ___ Very concerned

___ Elopement (running away from home or from adults when in public places):_____

_____

_____

How frequent: ___ Hourly ___ Daily ___ Weekly ___ Monthly ___ Yearly

How concerned: ___ Not concerned ___ Somewhat concerned ___ Very concerned

___ Other: _____

_____

_____

How frequent: ___ Hourly ___ Daily ___ Weekly ___ Monthly ___ Yearly

How concerned: ___ Not concerned ___ Somewhat concerned ___ Very concerned

Please provide information about the child's preferences and aversions:

Please tell us about the child's most favorite things. What does he/she like to play with, eat, drink, etc.? What types of activities does he/she enjoy?

_____

_____

_____

_____

_____

Please tell us about the child's least favorite things. Are there certain sounds, textures, tastes, activities, or items that he/she does not like?

_____

_____

_____

_____

_____

Please tell us about successes and challenges with previous intervention services:

If the child received intervention services in the past, and experienced success, please let us know what contributed to that success. What did therapists do to help the child? What did you think was beneficial about the services?

_____

_____

_____

_____

_____

_____

If the child received intervention services previously, and did *not* experience success, please let us know what contributed to the lack of success. What did therapists do that did *not* work for the child? What do you think could have been done differently to help the child?

_____

_____

_____

_____

_____

_____

Please tell us what you hope the child will gain from ASB participation.

By the end of ASB intervention, what skills would you like the child to have? In other words, two years from now, if this program is successful, what will the child be doing that he/she is not currently able or willing to do?

_____

_____

_____

_____

_____

Please provide additional information:

Is there any additional information about your child or family that would be important for us to know?

_____

_____

_____

_____

_____

Please indicate if parent/guardian would like to be contacted:

Would the parent/guardian like an ASB staff member to contact them to address questions or concerns about ASB services?

___ No, there are no questions or concerns at this time.
___ Yes, please contact now.
___ Yes, but not until the month prior to services starting.

Would the child's parent/guardian like to be contacted by a Resource Specialist to learn about community-based autism programs and supports that may be available? ___Yes ___ No

If you answered "Yes" to either question, please indicate what day(s) and time(s) are best to call:

_____

Please indicate how you heard about the ASB program:

___ Word of mouth (i.e., heard about it from a friend or family member)
___ DOH website
___ UNM CDD website
___ ASB provider agency: _____
___ Referral from another service provider: (please indicate) _____
___ New Mexico Autism Society listserv or other autism-specific listserv
___ Other: _____

Please provide information about who completed this application:

Who filled out this application?

Name: _____

Relationship to child: _____

Did anyone else assist in completing the application? ___ Yes ___ No

Name: _____

Relationship to child: _____

Please read the following and provide the signature of child's legal guardian:

As the child's legal guardian, I have reviewed this application and confirm that, to the best of my knowledge, the information provided is accurate. I understand that, if there are any changes, it is my responsibility to notify the ASB program so that their records can be updated accordingly. This includes, but is not limited to, a change in the child's diagnosis, custody, medication, special education eligibility, residence, etc. I also understand that it may take up to 3 months for my child's application to be reviewed. I understand that, should it be determined that my child is eligible for ASB services, this application and accompanying records will be provided to the ASB agency that will ultimately render intervention services to my child. Should I have any questions or concerns, I understand that I may contact the ASB program at 1-800-270-1861.

_____ _____

Signature of Legal Guardian Date

_____

Printed Name