



Application Form

| | | | |
|---------------------|---|----------------------|---|
| General Information | Date | | |
| | Child's Last Name | Child's First Name | Child's Middle Name |
| | Date of Birth | Gender | SS# |
| | Address | | |
| | Primary Language | | Secondary Language |
| | Guardian's Name(s) | | Marital Status |
| | Guardian's Phone Number(s) (H) (W) (C) | | Guardian's Phone Number(s) (H) (W) (C) |
| | Email (1) | | Email (2) |
| | Primary Insurance Company | Policy Holder's Name | Policy Holder's DOB |
| | Group Number | Policy Number | ID Number |

| |
|---|
| Would you like someone to contact you to give you more information? |
| Would you like someone to contact you to set up a tour? |

| | | | | | | |
|------------------|--|---------|-----------|-----------|----------|--------|
| Schedule Request | Please select the session(s) and fill out the hours/days your child will be available. Note: This schedule will ultimately be determined by need (staff availability, child's clinical need based on assessment, etc). | | | | | |
| | Fall 20__ (September-December) | Monday | Tuesday | Wednesday | Thursday | Friday |
| | | | | | | |
| | Winter 20__ (December-May) | Monday | Tuesday | Wednesday | Thursday | Friday |
| | | | | | | |
| | Summer 20__ (June-August) | Monday | Tuesday | Wednesday | Thursday | Friday |
| | | | | | | |
| Other: 20__ | Monday | Tuesday | Wednesday | Thursday | Friday | |
| | | | | | | |
| Comments: | | | | | | |

| | |
|--------------------------|------------------------------|
| Child Description | Briefly describe your child. |
|--------------------------|------------------------------|

| | |
|------------------------|---|
| Treatment Goals | What are your treatment goals for your child? |
|------------------------|---|

| | |
|--------------------------------------|---|
| Treatment/Educational History | <p>Please describe your child's past and current treatment history. Include intensive behavior therapy, speech therapy, occupational therapy, music therapy, etc. (Attach or separately mail any applicable documents).</p> |
| Treatment/Educational History | Does your child attend a school program? |

| | | |
|------------------------|--|--------------------------|
| Office Use ONLY | 1. Date Received: | 5. Mailed Intake Packet: |
| | 2. Follow-up Phone Call/Email Date: | 6. HC Contract Signed: |
| | 3. Tour Scheduled: | 7. Start Date: |
| | 4. Meeting Scheduled with Clinical Director: | |
| | Additional Information | |