Texana Behavior Treatment & Training Center
1818 Collins Road
Richmond, TX 77469
http://www.texanacenter.com/bttc
281-238-6789 Fax
1-800-304-6047 or 1-281-239-1140 Phone

Kate Johnson-Patagoc, Director

Application for Residential Services

Thank you for your interest in the Behavior Treatment and Training Center (BTTC). The BTTC provides short term residential services to Medicaid eligible children who meet the following criteria:

1. **Age:** 8 years old to 17 years old. Each child must have a legally authorized representative for consent purposes (ex. Parent, guardian or managing conservator)
    a. Who have a diagnosis of Intellectual or Developmental Disability (IDD) or Autism Spectrum Disorder (ASD
        i. An Adaptive Behavior Level (ABL) of II, III or IV is required for individuals who are diagnosed with an Autism Spectrum Disorder (ASD) without having IDD diagnosis.
    b. Who are eligible for ICF-IID level of care,
    c. Who reside in the community with parents or in a small group home,
    d. Whose family or group home commits to taking them back upon discharge,
    e. Who are determined by the BTTC IDT to be in need of active treatment, and decision by the BTTC IDT whether they can provide for the Individual's needs and whether the Individual is likely to benefit from admission,
2. **Behavior:** The Individual's behavior must threaten continued residence in family home or group home, pose imminent risk of injury, or severely disrupt current programming or services in the community.
3. **Service Area:** All Texas Counties.
4. **Discharge Site:** Prior to admission, each family or group home must agree to take the Individual back in the home or group home.
5. **Family Involvement:** Family and group home personnel must commit to learn and practice specific skills necessary for the Individual's behavior to continue improving even after discharge. This will involve regular meetings at the BTTC.
6. **Payment:** Child should be receiving Medicaid benefits or be able to meet all financial and medical diagnostic criteria to qualify for SSI with Medicaid upon admission. For children receiving child support payments, Social Security, Survivor's benefits, Adoption Subsidy or children with known resources & assets, may have to pay the Applied Income (AI). Once the correct Applied Income is determined by the Health & Human Services Commission, family must pay the AI retroactive to the admission date within 30-days of receiving notice either from Texana Center of HHSC. Future Applied Income is paid to the Texana/BTTC every month in advance of receiving services. In addition, family must agree to pay room & board of no more than $646.00 per month as determined by the financials. Room & board is charged on a sliding scale depending on current financial report as completed by the Local Intellectual Developmental Disability Authority (LIDDA's) indicating the family's Maximum Ability to Pay (MAP).
7. **US Citizen:** Applicants must be legal US citizens, or have been a permanent resident of the US for at least 5 years.

Please complete the following application as thoroughly as possible and attach all appropriate documents as requested. For assistance in completing the application, contact your service coordinator through your Local Intellectual Developmental Disability Authority (LIDDA's). For information about the BTTC, email **Alyssa Martin** at alyssa.martin@texanacenter.com or **Tracy Woods** at tracy.woods@texanacenter.com. You can also call Alyssa or Tracy at: 281-239-1140.

Forward completed application with all of the following documents attached:

1. ICAP computer scores and booklet –Not older than 3 years– Local Intellectual Developmental Disability Authority (LIDDA's)
2. Determination of Intellectual Disability or related condition – Local Intellectual Developmental Disability Authority (LIDDA's)
3. Copy of the current financials indicating Maximum Ability to Pay (MAP) as determined by Local LIDDA's
4. Psychiatric hospitalization discharge reports
5. Copy of child's Medicaid card – front & back
6. Copy of current private health insurance card (front & back)
7. Copy of child's birth certificate
8. Copy of child's Social Security card
9. Copy of child's immunization record – From current school where child is enrolled
10. Copy of legal document – if caregiver is not the natural parent or if child has joint custody

Application for BTTC Residential Services

Date Application Completed: _____

CHILD'S IDENTIFYING INFORMATION

Name of Child				**DOB**		**Age**	
SS #		**Race**		**Gender**		**Care ID**	
County of Residence				**Local IDD**			
Height		**Weight**		**Current ISD**		**Grade**	

Medicaid Type: ☐ Traditional ☐ CHIPS ☐ Other (please specify): _____ **Medicaid Number:** _____

☐ CPS/Adoption Subsidy ☐ TX Star Plus ☐ HMO _____

Citizenship (check appropriate status): ☐ US ☐ Permanent Resident (how long): _____ ☐ Other: _____

Parent/Legal Guardian Information	**Service Coordinator's Information**
Name:	**Name:**
Address:	**Address:**
Phone #:	**Phone #:**
Email:	**Email:**

LIDDA Liaison/Administrator:		**Phone #**	
LIDDA Administrator's Email:			

SERVICES BEING REQUESTED

Briefly describe what is currently happening that has led you to seek services from the BTTC:

BEHAVIOR STATUS: Please tell us if each of the following behaviors occurred within the last 2 months.

Inappropriate Behaviors	Yes	No	Inappropriate Behaviors	Yes	No
Aggression to Others: Hitting, kicking, scratching, biting, head butts, etc	☐	☐	**Inappropriate Sexual Behavior:** groping or touching self or others.	☐	☐
Self Injury: Hitting, biting, scratching, head banging, etc	☐	☐	**Running Away or Leaving Assigned Area:** Does child run into traffic?	☐	☐
Property Destruction: Throwing or breaking objects, kicking walls, etc.	☐	☐	**Ingestion of Inedible Objects (pica):**	☐	☐
Theft: Stealing food, money, or other items from home, school or stores, etc.	☐	☐	**Inappropriate Language Use:** Cursing, threatening others, screaming, etc	☐	☐
Drops to Ground:	☐	☐	**Lying on Others or making false statements:**	☐	☐
Suicidal Attempts/Threats	☐	☐	**Other:**	☐	☐

What is the most severe problem behavior(s)?

	Problem Behavior	Definition
1		
2		
3		

Critical Situations When Problem Behaviors occur (for most serious problem behaviors listed above)

Problem	When did this problem behavior begin?	How Often Does it Happen?		
		Daily	Weekly	Monthly
# 1 Above				
# 2 Above				
# 3 Above				

Describe a situation in which the **most serious problem** behavior is **most likely** to occur. _____

Describe a situation in which the **most serious problem** behavior is **least likely** to occur. _____

Is the child most likely to hit other children, parents, family members, teachers, strangers or does the child hit all people as listed equally? _____

Negative Effects of Most Severe Problem Behaviors:

Are there any places you cannot take your child because of his/her problem behaviors? If yes, please list and explain what happens when you take the child there. _____

Restraint (physically holding child to prevent injury to child or other people):

Has **restraint** been used for these problem behaviors? ☐ Yes ☐ No. If Yes, what type of physical **restraint** is used? _____ How often this type of restraint is used (☐ daily ☐ weekly ☐ monthly)

Has containment (restraint) been used in the home? ☐ Yes ☐ No _____

Has containment been used at school or group home? ☐ Yes ☐ No _____

What happens soon after the containment? ☐ Child resumes original activity ☐ Child allowed to rest ☐ Child given something he/she wants ☐ Child placed in time out ☐ Other _____

Does Child have a behavior support plan? ☐ Yes ☐ No. If yes, who developed the plan? _____. When was plan developed? _____.

What do you do when your child misbehaves? ☐ Time out ☐ Loss of privilege ☐ Ignore behavior ☐ Punish Child by _____ ☐ Other Consequence _____

What do you do when your child is behaving well? ☐ Praise ☐ Ignore child because he/she needs to behave well anyway ☐ Give child what he/she wants ☐ Other _____

How effective are these strategies? ☐ Very effective ☐ Marginally effective ☐ Not effective at all

☐ Plan used to work but not anymore. Why do you think the plan no longer works? _____

Medical Treatment

Have any of these problem behaviors caused anyone to seek medical attention for injuries? ☐ Yes ☐ No

If yes, please explain _____

Police Involvement

Have any of the listed problem behaviors caused anyone to call the police or other law enforcement agency to intervene?

☐ Yes ☐ No. Explain if yes: _____

Has child ever been arrested? ☐ Yes ☐ No. If yes, did child see judge? ☐ Yes ☐ No

Is child on probation? ☐ Yes ☐ No If yes, how long is probationary period? _____ Months.

What is the offense child is charged with? _____

Hospitalizations

Have these problem behaviors listed caused child to be admitted to psychiatric hospital or other such facility?

☐ Yes ☐ No. If yes, what behaviors led to hospitalization? Please complete table below:

Name of Institution Admitted	Reason for Admission	Admit Date	DC Date

Program Discharges

Have any of the problem behaviors caused a school, hospital, or any other residential program to discharge child?

☐ Yes ☐ No. If yes, please list program names and dates child was discharged.

Name of Program Discharged From	Reason for Discharge	Date Discharged

Functional Skills

Please circle one item for each of the question that represents how your child does.

1. **Talks or communicates with:** ☐ Non verbal signs or gestures ☐ single word ☐ 2-3 words ☐ complete sentences.
2. **Feeding:** ☐ Unable to feed self ☐ with fingers only ☐ uses utensils but need assistance ☐ independent in feeding
3. **Toileting:** ☐ Needs toilet training ☐ uses toilet when prompted ☐ needs assistance when toileting ☐ Independent
4. **Teeth Brushing:** ☐ Needs total assistance ☐ Needs slight assistance ☐ Brushes teeth independently
5. **Dressing:** ☐ Needs total assistance ☐ Needs slight assistance ☐ Dresses independently
6. **Bathing:** ☐ Needs total assistance ☐ Needs slight assistance ☐ Bathes independently
7. **Playing:** ☐ Does not play with toys ☐ plays appropriately with toys ☐ plays by self ☐ Plays appropriately with others.

8. How does child communicate to others a **need or a want** (for attention, food, etc)?
   ☐Verbal ☐ signing ☐ pictures ☐ gestures & pointing ☐ other: _____
9. How does child communicate a desire to stop an ongoing activity? _____
10. How many hours per night does the child sleep on average? _____ Hrs.
11. Does child need medications to sleep? ☐ Yes ☐ No. If yes, what drug is used? _____
12. What adaptive equipment does child use? ☐ Prescription eye glasses ☐ Special Utensils ☐ Wheelchair
    ☐ leg braces ☐ Hearing aids ☐ Special shoes ☐ Vagus Nerve Stimulator (VNS)
    ☐ Pace maker ☐ Other: _____
13. Other: _____

CHILD'S FINANCIAL INFORMATION (List money that family gets on behalf of child)

Social Security Income (SSI): $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly: Used to pay Room & Board

Supplemental Security (SS): $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly:

Child Support Payments: $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly:

Adoption Subsidy Payments: $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly:

Rail Road Retirement Payments: $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly

Other Income & Sources: $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly _____

Private Health Insurance Provider: _____ **Policy #:** _____

Doctor's Co-Pays: $ _____.00 **Prescription Drugs Co pays: $** _____.00**, $** _____.00**, $** _____.00

Maximum Ability to Pay (MAP) as determined by Local Authority: $ _____.00 Weekly / Bi-Monthly / Monthly / Yearly:

MEDICAL HISTORY

Date of last doctor visit		**Reason**	
Date of Last Physical Exam			

Please list all medications currently being taken by child that are prescribed by a medical physician: see example below:

Name of Medication	Strength	Frequency	Reason
Depakote ER **(example)**	500 MG	2 tabs by mouth x 2 Daily	Seizures

Name of current Psychiatrist		Phone #	

Does child take his/her own medications? ☐ Yes ☐ No. **Can child swallow pills?** ☐ Yes ☐ No.

Please explain how medications are given and how cooperative the child is: _____

_____

Please list psychotropic drugs that have been tried and discontinued in the past & reason(s) for discontinuation:
(Attached separate paper as needed).

Name of Drug	When Used	Reason Discontinued

Tell us about current health problems or complaints

1. **Does child have seizures?** ☐ Yes ☐ No. If yes, list date of last seizure: _____ Type of seizures: _____ How long do seizures last? _____ sec / min
2. How often do seizures occur? _____ / day / week / month / year. What do you do when child has seizure? _____
3. **Is child under care of Neurologist?** ☐ Yes ☐ No. Name of Neurologist: _____
4. **Does child have Diabetes?** ☐ Yes ☐ No. If yes, list medication taken:_____
5. **Does child have high blood pressure?** ☐ Yes ☐ No. If yes, list medication taken: _____
6. **Does child have Asthma?** ☐ Yes ☐ No. If yes, list medication taken: _____
7. **Does child have Heart Condition?** ☐ Yes ☐ No. If yes, list medication taken: _____
8. **Name of Cardiologist:** _____ **Phone #**: _____
9. **Does child have any other medical/health problems?** ☐ Yes ☐ No. If yes, explain: _____
   _____
10. **Does child have any dental problems?** ☐ Yes ☐ No. Explain "Yes" _____
11. **Date of last dental visit:** _____ **Results**: _____
12. **Has child been hospitalized (for health reasons) in the past two years?** ☐ Yes ☐ No. If yes, please list: _____
13. **Date last hospitalized:** _____ **Reason:** _____
14. **Name of Hospital:** _____ **How long Hospitalized:** _____
15. **Has child had any surgeries?** ☐ Yes ☐ No. If yes, when? _____
16. Type of surgery: _____
17. Has child had any significant **weight Gain** or **Loss** in last 12 months? ☐ Yes/**Gain** ☐ Yes/**Loss** ☐ No.
18. Explain weight **Gain or Loss:** _____
19. **Is child on a special diet <u>prescribed by a doctor</u>?** ☐ Yes ☐ No. If yes, type of diet: _____
20. **Does child have any physical limitations?** ☐ Yes ☐ No. Describe Limitations if yes by outlining specifically what the child can or cannot do: _____
21. Other:

This Section is for female applicants only

Has child begun her menstrual cycle? ☐ Yes ☐ No. Year cycles begun: _____

If Yes, are menstrual cycles normal? ☐ Yes ☐ No. If no, explain: _____

Is child on any form of birth control? ☐ Yes ☐ No. If No, what form of birth control? _____

If child able to care for her hygiene during menstruation? ☐ Yes ☐ No. If no, how much assistance does child need?

☐ Total assistance ☐ Some assistance ☐ Verbal prompting through ☐ Other: _____

This Section is for all applicants

List all allergies child has:

Food Allergies	Drug Allergies	Other Allergies

Does child have hearing problems? ☐ Yes ☐ No. If yes, does child wear hearing aids? ☐ Yes ☐ No.

Does Child have Visual Problems? ☐ Yes ☐ No. Does child wear prescription glasses? ☐ Yes ☐ No.

Date of Last Visual Examination: _____

Does Child Have Gait or Ambulation Problems? ☐ Yes. ☐ No. If Yes, Explain. _____

Information on the person completing the form:

Name		**Phone No**			
Relation to Child		**Cell No**			
Home Address		**City**		**Zip:**	
Email Address		**Other**			

Parent Training Preference & Commitment

I/We agree to attend training sessions at the BTTC on the following schedule: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

I/We agree to attend a minimum of 40 hours of training during my/our child's stay as follows: ☐ 2 Hrs. ☐ 3 Hrs.

☐ ½ Day ☐ Full Day ☐ Other Schedule (explain) _____ per training session.

If the person completing this application form is other than the parent or Legally Authorized Representative (LAR), the LAR must read the application and sign below acknowledging the accuracy of the information in the application.

I/We acknowledge the information contained in this application to be accurate to the best of my recollection and that I am seeking **short term residential services for my child.**

Signature: _____ Relationship to child: _____

Mail Completed application with all attachments to:

Admissions

Behavior Treatment & Training Center
1818 Collins Road
Richmond, TX 77469-2759

Or Fax or scan & email to:

Fax: 281-238-6789

Email: tracy.woods@texanacenter.com

Or, alyssa.martin@texanacenter.com

Appendix 1

ICD 10 ICF-IID Qualifying Diagnosis

Intellectual Disabilities F70-F79

Code	Version	IQ Range	Diagnosis
F70		50-70	Mild Intellectual Disability
F71		35-49	Moderate Intellectual Disability
F72		20-34	Severe Intellectual Disability
F73		<20	Profound Intellectual Disability
F78		Unspecified	Other Intellectual Disability
F79		<75	Unspecified Intellectual Disability
R41.83		71-84	Borderline Intellectual Functioning

Individuals with any of the above diagnosis F70-F79 may have any ABL of I, II, III or IV and or any other diagnosis listed below.

Pervasive and Specific Developmental Disorders – F80 –F89

Code	Version	IQ Range	Diagnosis
F80			Specific developmental disorder of speech & language
F81			Specific developmental disorder of scholastic skills
F82			Specific developmental disorder motor function
F84			Pervasive developmental disability
F88			Other disorders of psychological development
F89			Unspecified disorders of psychological development

Individuals with diagnosis F80 – F89 must have an ABL of II, III or IV in the absence of a diagnosis covered in F70 – F79. If individual has a diagnosis in group F70 – F79 and in group F80 – F89, the individual may have an ABL of I and qualify for ICF-IID services.