Thank you for your interest in the Texana Children's Center for Autism (CCA) and Behavior Stabilization Team (BeST). Please complete the following application for services as thoroughly as possible and attach all appropriate documentation as noted. Your child will be placed on the interest list as of the date the application is received. Completed applications should be emailed to CCAAdmissions@texanacenter.com.

Today's Date: _____

Applied Behavior Analysis (ABA) Treatment Options (descriptions on pages 5 and 6):
Please select your desired the service and service location:

□ Comprehensive ABA Treatment (15-40 hours per week) available to children with insurance that covers ABA or private pay only:

□ Rosenberg Location: 4910 Airport Ave, Rosenberg, TX
- Serves children from age of diagnosis to 21 years old

□ Fulshear Location: 7440 FM 359 S., Fulshear, TX 77441
- Serves children from age of diagnosis to 8 years old

□ Focused ABA Treatment – HHSC Children's Autism Program (less than 15 hours per week) available to children with Medicaid or insurance policies that do not cover ABA:

□ Rosenberg Location: 4706 Airport Ave, Bldg. C, Rosenberg, TX
- Serves children ages 3-15 years old

Scheduling:
Please complete this section for Comprehensive ABA services:
The child's treatment schedule will be determined based on medical necessity for ABA. Treatment dosage (i.e., hours per week and duration of treatment) will be determined by the results of the initial ABA assessment, recommendation by referring physician, and other clinical factors. Authorization must also be approved by your child's insurance. While we are unable to determine your child's recommended treatment schedule prior to the assessment, it is helpful to know about any scheduling limitations. Please select one of the options below:

- □ My child can be available for any recommended treatment schedule including part days (such as 8:30am-12:00pm or 12:00pm-4:00pm)
- □ Due to school, transportation, or other factors, my child is only available for treatment during these times:
  - Monday: _____
  - Tuesday: _____
  - Wednesday: _____
  - Thursday: _____
  - Friday: _____

For *Focused ABA Services,* note the session block(s) you most prefer:

□ Morning (8:30 AM – 11:30 AM)

□ Afternoon (1:00 PM – 4:00 PM)

□ First Available

Child Information:

Child's legal name: _____

Child's preferred name: _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Sex: _____

Ethnicity (required by funding source): _____

Current educational and/or treatment setting: _____

Diagnostic Information:

Date of initial Autism diagnosis: _____

Age at diagnosis: _____

Who provided the initial Autism diagnosis? _____

What was the credential of the diagnostician? MD, PhD or Other: _____ (circle one)

Date of Autism re-evaluation (if applicable): _____

Additional Diagnoses (if applicable): _____

History of ABA services:

If your child has received more than one type of service or has received ABA treatment at more than one provider, please provide the information for each type of service/provider below

Most Recent ABA Provider: _____

Service Dates: _____

Hours per week: _____

Response to treatment: _____

Reason for discharge: _____

Past ABA Provider: _____

Service Dates: _____

Hours per week: _____

Response to treatment: _____

Reason for discharge: _____

Parent/Guardian Information:

Name Parent/Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Relationship to applicant: _____

Phone: _____

Email: _____

Please circle your preferred method of communication: Phone (voice calls only) or email
Please note that email is the primary mode of communication used by Texana Center during the admission process.
Preferred language of parent or caregiver: _____
Preferred language of child (N/A if child does not speak): _____
How did you find out about the Children's Center (doctor, psychiatrist, friend, internet, ECI etc.)?
_____
Did your child receive Early Childhood Intervention (ECI) services? Yes or No (circle one)

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

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

Allergies/Hypersensitivities: Allergies do not prohibit a child from accessing services. This information is required to ensure that our facility is prepared to treat your child.

Allergy (what is the child allergic to?)	
Date of Onset	
Status (confirmed or suspected)	
What does the reaction look like?	
How severe is the allergy? (mild, moderate, life threatening, etc.)	
Treatment (Note: if an EpiPen is required, this will be required at admission)	
Other Comments	

Adaptive Behavior: Please tell us about their level of independence.

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

Behavior Assessment: Please check all that apply.
***Communication*:**
□ No discernible speech sounds (no sounds or only 1-2 sounds)
□ 3 to 5 discernible speech sounds

□ Babble consisting of 5 + speech sounds
□ Can say at least 10 words
□ Echolalia (repetitive sounds; repeating words or phrases)
□ Uses words or short phrases to communicate wants and needs or label
□ Primary mode of communication is sign language. Approximate number of signs _____
□ Primary mode of communication is PECS. Approximate number of PECS _____

Motor or Vocal Self-Stimulatory Behaviors (examples: repetitive phrases, hand flapping, spinning, rocking):

□ Motor self-stimulatory behaviors occur in most all settings, including during interactions with others
□ Vocal self-stimulatory behaviors occur in most all settings, including during interactions with others
□ Motor self-stimulatory behaviors occur primarily when the child is not engaged by another person
□ Vocal self-stimulatory behaviors occur primarily when the child is not engaged by another person
□ Does not engage in motor or vocal self-stimulatory behaviors

Aggression to Self (AS):

□ _____ times per day ____ times per week
□ _____ occurs only at school ____ occurs only at home ____ occurs in all environments
□ Self-injurious behaviors cause injury such as bleeding or bruising
□ Self-injurious behavior causes redness that does not bruise
□ Self-injurious behavior occur at low frequency that does not cause injury
□ Does not engage in self-injurious behaviors

Aggression to Others (AO):

□ ____ times per day ____ times per week
□ ____ occurs only at school ____ occurs only at home ____ occurs in all environments
□ ____ AO towards adults only ____ AO towards children only ____AO to children and/or adults
□ Physically aggressive behaviors against others cause bleeding or bruising
□ Physically aggressive behaviors against others cause redness that do not bruise
□ Physically aggressive behaviors against others occur at a low frequency that does not cause injury
□ Does not engage in aggression to others

Other maladaptive behaviors:

□ Aggression to the Environment/Property (AE), such as throwing furniture, destroying materials, etc. If yes, ____ times per day, ____ per week
□ Pica (ingestion of inedible substance). If yes, ____ times per day, _____ per week
□ Unauthorized departure. If yes, ____ times per day, _____ per week
□ Verbal aggression. If yes, ____ times per day, _____ per week
□ Spitting. If yes, ____ times per day, _____ per week
□ Inappropriate sexual behaviors. If yes, ____ times per day, _____ per week
□ Theft. If yes, ____ times per day, _____ per week
□ Other: _____

<u>Insurance Coverage Information</u>:

☐ **Child has NO insurance at all**

Medicaid / CHIP Coverage
☐ Child has Medicaid or CHIP coverage ☐ Child does not have Medicaid or CHIP coverage
If the child is covered by Medicaid or CHIP, please complete the following:

Information	Details
Medicaid MCO Name	
Medicaid MCO Member ID	
CHIP MCO Name	
CHIP MCO Member ID	

Private Insurance Coverage	
☐ Child has Private Insurance coverage ☐ Child does not have Private Insurance coverage	
If the child is covered by private insurance, please complete the following:	
Information	Details
Insurance Company Name	
Telephone Number for Providers	
Primary policy holder's name	
Social Security Number	
Policy Number	
Group Number	
Effective Date	
Primary policy holder's employer:	

Comprehensive Program Description (Insurance/Private Pay):

- Summary: The Children's Center for Autism is a comprehensive program that provides 1:1 Applied Behavior Analysis (ABA) services. The program operates year-round except designated holidays. The program is directed, managed, and supervised by Board Certified Behavior Analysts (BCBA). Parents have open on-site access to video monitoring of their child's daily treatment sessions. The principles of ABA are used to teach functional replacement behaviors and skills in the areas of language and communication, social interaction, adaptive behavior, pre-academics, etc. Treatment also includes intervention to reduce behaviors that are dangerous, impede learning or functioning, or restrict access to a variety of settings. Parent involvement is required and training is offered in the clinic, home, and community.
- Age Requirements: Age of diagnosis-21 years
- Counties Served: there are no restrictions; family must provide transportation
- Required Diagnoses: Autism Spectrum Disorder provided by an MD or PhD (if filing for insurance reimbursement)
- Additional paperwork required before admission:
    - Proof of diagnosis on the Autism Spectrum by a PhD or MD
    - A copy of your insurance card
    - A copy of your Medicaid card (if applicable)
    - A copy of the driver's license or identification card of the policy holder
    - A prescription or letter from a physician recommended ABA treatment if not specifically written into the evaluation report

Focused ABA Program Description (HHSC Children's Autism Program):

Summary: The BeST HHSC CAP program is a 1:1 focused ABA Program. The programs are directed, managed, and supervised by a Board-Certified Behavior Analysts (BCBA). A BCBA with the help of behavior technicians will work directly with your family in the home, community, school, via telehealth, or clinic setting. An initial behavior assessment is completed with each child. Based on the results of the assessment and parent priorities for assistance, appropriate treatment goals are selected. The principles of ABA are used to teach these skills.

- Hours: Children receive up to 180 hours of treatment in a 12-month period. Depending on the child's needs and BeST availability, an appropriate treatment schedule will be determined for your child. The child must attend at least 85% of the scheduled session time each month, and over the duration of the treatment. Parents are required to be present for each session and actively participate in weekly parent collaborative coaching with the BCBA. Not meeting these requirements may result in discharge from the HHSC program. Services cannot exceed more than 180 hours in a 12-month rolling period, and services end after the child has accumulated 720 hours of treatment or has reached 16 years of age. At the end of focused treatment, families are notified about any applicable options for future services.
- Fee for Service: Sliding scale based on income and family size
- Age Requirements: 3 through 15 years
- Counties Served: Austin, Colorado, Fort Bend, Matagorda, Waller, Wharton, Harris, Liberty, Montgomery, Walker, Brazoria, and Galveston; families must be able to provide transportation to and from treatment.
- Required Diagnoses: An autism spectrum disorder is required
- Additional paperwork required before admission:
    - Proof of diagnosis on the Autism Spectrum by a PhD or MD (preferred) or an LSSP
    - A copy of your insurance card or Medicaid card
    - A copy of the driver's license or identification card of the policy holder
    - A prescription or letter from a physician recommended ABA treatment if not specifically written in the evaluation report; Texana can provide you with an example.
    - A copy of your 1040 from your most recent income tax return
    - Proof of residency (electricity bill, water bill, etc.)
    - A copy of the child's most recent IEP if one exists
    - The following documents will be given to you and signed electronically:
        - Payment Arrangement
        - HHSC Enrollment Form
        - HHSC Cost Share Attestation Form
        - Completed HHSC Parent Manual including method of payment

Your child will be placed on the interest list upon receipt of the completed application. Start dates will not be determined until all required paperwork is received.

Completed applications should be emailed to CCAAdmissions@texanacenter.com or faxed to 281-238-6769**.**