ENROLLMENT APPLICATION

for the Behavioral Health Clinic (BHC) at The Faison Center

Please complete and return this form to :
The Admissions Office

admissions@faisoncenter.org

Please complete the following application and provide these additional items (as applicable):

1) Most recent psychological reports and/or evaluation reports, containing any diagnoses
2) State School Health Entrance Form (including physical exam and immunization record)
3) Most recent IEP, ISP, or 504 Plan
4) Most recent Eligibility meeting minutes (for Special Education services)
5) Most recent Behavior Intervention Plan and/or Functional Behavior Assessment
6) Other recent evaluations (ABA, feeding therapy, OT educational, speech, etc.) from within the last 2 years.
7) Prescription for ABA therapy from medical professional (Pediatrician, Developmental Pediatrician, Psychologist, etc)
8) Copy of current Insurance card (front and back)

Thank you for your interest in The Faison Center! Upon receiving a completed application, the team will review this form and accompanying documents. After reviewing this information, we will contact you to set up an Intake appointment. If you should have any questions or need assistance, please call us at the above phone number, or send an email to the above address.

PART I – BIOGRAPHICAL INFORMATION

Client/Applicant's Name ____

Nickname ______________________ **Date of Birth** ______________________

Gender __________________ **County of Residence** ______________________

Application Completed By ____________________ **Date Completed** ______________

Relation to Client/Applicant ____________________________

Telephone __________________ **Email** ______________________________

Parent/Guardian #1

Name __________________________ **Relation to Applicant** ______________

Address ____

Phone __________________________ **Email** __________________________

Age ____________ Occupation __________________________ Marital Status _______________

Parent/Guardian #2

Name __________________________________ Relation to Applicant _____________________

Address ____

Phone __________________________________ Email __________________________________

Age ____________ Occupation __________________________ Marital Status ________________

Does the applicant live at the same address as parent/guardian? □ Yes □ No

If Yes, does the applicant reside with both parents/guardians or one?

□ Both □ Only Parent/Guardian #1 □ Only Parent/Guardian #2

*****If applicable, please provide a copy of legal custody documentation with application*****

Part II – MEDICAL

Does the Applicant have medical insurance? □ Yes □ No

Name of Insurance Provider ____

Policy # _____________________________ Subscriber Name ___________________________

Group # __________________________________

Company Name (if through employer) ____

If seeking insurance coverage for services, please provide a copy (front & back) of insurance card

Primary Care Physician/Pediatrician ___________________________ Telephone _______________

List All Current Psychiatric or Developmentally Related Diagnoses

Diagnosis	Year Diagnosed	Diagnosing Physician

List All Current Medical Diagnoses/Issues

Diagnosis	Year Diagnosed	Diagnosing Physician

List Any Previous Diagnoses

____

List Medical Equipment and/or Treatments

____

____

ALLERGIES (Food, Medication, and Environmental)

Allergen	What Symptoms Occur	Treatment for Allergic Reaction	Formally Tested or Suspected?

MEDICATION
List all information for each *current* medication (prescription and over the counter)

Drug/Medication Name	Date Started	Dosage	Purpose	Has It Been Effective?

What other medications have previously been prescribed or taken but are no longer being administered?

____

____

Does the applicant take any other vitamins or supplements? **□ Yes** **□ No**
If Yes, please list ____

Hospitalizations, Testing, and Evaluations

Hospital Name	Month/Year	Reason

Surgeries

Hospital Name	Month/Year	Reason

NEUROLOGICAL

Is there a history of seizures? ______________ Age of Onset ______ Date of last seizure _________

How often do seizures occur now and how long does one last? _________________________________

Describe what seizure activity looks like

____

____

Describe any other neurological problems

____

____

Date of last neurologist visit ____

Neurologist's Name _____________________________ Telephone _______________________

EYES

Are there any problems with vision? ______________ If yes, explain ___________________________

Glasses? □ Yes □ No How often are glasses worn? ___________________________

What issue do the corrective lenses address? ____

EARS, NOSE, THROAT

Are there any problems with hearing? _____________ If yes, explain __________________________

Hearing Aid ____________ How often is hearing aid worn? _________________________

DENTAL

Are there any problems with current condition of teeth? _____________ If yes, explain ____________

____

Past dental procedures & dates ____

____

ADDITIONAL SPECIALISTS (Psychiatry, Cardiology, Orthopedics, GYN, etc)

Physician's Name	Specialty	Reason for Being Seen

OTHER PREVIOUS MEDICAL TESTS & EVALUATIONS (List Type & Date)

Chromosomes ____
Metabolic Studies____
Feeding/Swallowing ____
Gastrointestinal ____
Other ____

NUTRITION
Current Weight ______________ **Current Height** _____________________

Diet (check) □Regular □ Chopped □ Pureed □ Low Fat □ Other ___________________________

Describe any feeding problems (chewing, swallowing, choking, eating too fast, vomiting, food aversions, etc.) ____
____

PART III – SCHOOL HISTORY

Current School or Day Care _________________________________ **Telephone** _________________

County/City _________________

Type of Placement ______________ **Teacher/Therapist Name** _______________________________

In Classroom:
Number of Teachers & Aides ________ **Number of Clients/Students** _________
Does the applicant have a 1:1 Aide? □ Yes □ No

Other former schools/day cares attended

Name	Dates Attended	Reason for Leaving

Please list Community agencies/contacts who provide services to the applicant

Agency	Contact Name	Nature of Service

PART IV – PSYCHOSOCIAL/DEMOGRAPHIC BACKGROUND

Applicant's Race/Ethnicity (check one)
□White □Black/African American □Hispanic/Latino □Asian □American Indian/Alaskan Native □Other

This information helps Faison obtain monetary support from foundations and corporations that, in turn, helps us provide our specialized services:

Total Annual Household Income (please round to the nearest thousand) $____________________
Number of Dependents in the household _________________

Education Level	Guardian #1	Guardian #2
No High School Diploma		
High School Diploma or GED		
Associate or Bachelor's Degree		
Graduate or Professional Degree		

Who lives in the applicant's residence?

Name	Age	Gender	Relationship

What is the primary language spoken in the home? ____

If there are secondary languages, please write them here ______________________________________

PART V – BEHAVIORAL CONCERNS

Record each interfering behavior the applicant displays and describe it specifically. Include any damage resulting from the behavior either to the individual, others, and/or property. Please rank in order of concern to yourself or to other caregivers.

Behavior	Description	Occurs How Often	Damage to Self/Others/Property

Estimate the severity of the interfering behavior of greatest concern (check one)
□Minor □Moderate □Severe □Life Threatening

Has the applicant ever been sent to the hospital to treat an injury resulting from the behavior?
□Yes □No If yes, describe ____

Has the applicant ever injured someone in such a way that required them to seek medical treatment?
□Yes □No If yes, describe ____

Has the applicant ever been hospitalized to develop a treatment for these interfering behaviors?
□Yes □No If yes, describe ____

In what setting does interfering behavior occur (check all that apply)
□Home □School/Day Care □Community □Other (describe) ___________________________________

How long has the applicant been engaging in the interfering behavior (check one)?
□Within Past 6 Months
□More than 6 months, but less than 1 year
□More than 1 year, but less than 3 years
□More than 3 years, but less than 5 years
□More than 5 years, but less than 7 years

When is the interfering behavior likely to occur (check all that apply)
□When individual is left alone or unattended
□When lots of people are around
□When demands are placed on the individual
□When individual cannot have something they want
□Time of day
□Mealtimes, dressing, toileting, or bathing
□Other ____

Are there any situations or environments where the interfering behavior rarely or never occurs?
____
____

How do people (parents, staff, etc) typically respond when the individual engages in interfering behavior?
____
____

Is a formal program or intervention protocol currently being used? □Yes □No
If yes, please include with this application
How long has the program been in place? ____

Estimate the general trend of interfering behavior during the past year (check one)
□Increasing (Behavior getting worse) □Stable (about the same) □Decreasing (Improving)

Does the applicant display aggressive behavior toward adults or peers? □Yes □No

Was the onset of the problem behavior(s) associated with any specific events or series of events?
____

Have the following procedures ever been used to manage or treat the problem behavior(s)?
Restraint (describe) ____
Which interfering behavior was the treatment used for? ____________________________________
Start Date ___________ Still Used? ___________________________ Stop Date ____________
Degree of Success: □Poor □Fair □Good □Excellent

Protective Equipment (helmet, gloves, etc) ____
Which interfering behavior was the treatment used for? ____________________________________
Start Date ___________ Still Used? ___________________________ Stop Date ____________
Degree of Success: □Poor □Fair □Good □Excellent

Positive Reinforcement Procedures (describe) ____
Which interfering behavior was the treatment used for? ____________________________________
Start Date ___________ Still Used? ___________________________ Stop Date ____________
Degree of Success: □Poor □Fair □Good □Excellent

Time Out (describe) ____
Which interfering behavior was the treatment used for? ____________________________________
Start Date ___________ Still Used? ___________________________ Stop Date ____________
Degree of Success: □Poor □Fair □Good □Excellent

Corporal Punishment, Spanking, etc. (describe) ____
Which interfering behavior was the treatment used for? ____________________________________
Start Date ___________ Still Used? ___________________________ Stop Date ____________
Degree of Success: □Poor □Fair □Good □Excellent

Other (describe) ____
Which interfering behavior was the treatment used for? ____________________________________
Start Date ___________ Still Used? ___________________________ Stop Date ____________
Degree of Success: □Poor □Fair □Good □Excellent

What other treatments and/or therapies have been used, past or present?
____
____
____
____
____
____

PART VI – CURRENT PERFORMANCE

Communication Skills (check any that apply)
□Speaks freely and easily □Talks mainly in phrases □Uses single words □Sign Language
□Pictures □Communication device: _________________ □Other: _________________________

Dressing: □Completely independent □Requires some assistance □Requires full assistance

Toileting: □Completely independent □Has occasional accidents □Wears Pull-up/Diaper
□Other: ____

Mobility: Does the applicant have any mobility issues? □Yes □No
If yes, please describe ____
Does the applicant use any assistive equipment (wheelchair, braces, etc)? _________________________

Sleep Habits
Falls asleep easily? □Yes □Sometimes □No
Sleeps through the night without waking? □Yes □Sometimes □No
Time to Bed (PM) _________________ Time to Wake (AM) ___________________________

What frequency/type of supervision is required (check one)?
□Constant (1 on 1) □Individualized (small group) □Large group □Completely independent

Can be left alone for brief periods? □Yes □No
Needs continuous monitoring but can work in a group? □Yes □No

Please list preferred foods/activities
Favorite Foods ____

Favorite Toys ____

Favorite Activities ____

Favorite Types of Social Interaction ____

Are there certain items, activities, places, or environments that the applicant does not like? If so, please list. ____

What funding source do you plan to utilize for the program?

□Medical Insurance **□Private Pay**

If accepted to the EEC, what would success look like for the applicant after a year of services?

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____
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____

____
____
____

Please add any other details you feel would help us serve the applicant

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____
____
____

--_For office use only_---

Complete Application Received by Admissions on ___________________________________

Parent/Guardian Contacted for Intake on _______________________________

Intake scheduled for ___________ with ________________________

Application Reviewed on ___________________ Accepted or Rejected ____________________

Reason for Rejection ____

Acceptance/Rejection Letter Sent On ________________________________

Additional Information Required Before Decision:

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____
____

Notes ____

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