**Pre-Admission Application**

**Chrysalis Program**

**ABA Based Early Intervention**

Please complete this form and email to info@beckhombehaviorconsulting.com or mail or deliver to our office when done. Children diagnosed with Autism and other developmental disabilities ages 3-5 are eligible for this program. A select number of children who may serve as models will also be considered. We will accept a maximum of 15 children during this pilot program year. Enrollment is open until all spots are filled. Completed applications are processed in the order received. Incomplete applications will not be processed. A copy of your child’s IFSP OR IEP is required. If your child is accepted in the program, we will schedule an intake meeting with you and the Program Director.

Today’s Date: Click here to enter a date.

Does your child have Autism or a developmental disability? [ ] Yes [ ] No [ ] IFSP [ ] IEP [ ] Behavioral Plan

Child’s DOB: Click here to enter a date. Age:Click here to enter text. [ ] Male [ ] Female

Child’s Full Name: Click here to enter text. Diagnosis(es): Click here to enter text.

Child’s address: Click here to enter text.

Person filling out this application: Click here to enter text. Relationship to the child: Click here to enter text.

Phone: Click here to enter text. Cell: Click here to enter text. Who is the legal guardian? Click here to enter text.

How did you hear about us? ☐ Website ☐Agency ☐Another parent Referred by: Click here to enter text.

PARENT INFORMATION

Mother’s Name : Click here to enter text. Email: Click here to enter text.

Address:Click here to enter text. Home phone: Click here to enter text.

Work:Click here to enter text. Ext.:Click here to enter text. Cell:Click here to enter text.

Place of Employment/Occupation: Click here to enter text. Skill: Click here to enter text.

Father’s Name: Click here to enter text. Email: Click here to enter text.

Address:Click here to enter text. Home phone: Click here to enter text.

Work:Click here to enter text. Ext.:Click here to enter text. Cell:Click here to enter text.

Place of Employment/Occupation: Click here to enter text. Who is the legal guardian? Click here to enter text.

 Child’s Primary Residence:[ ]  Both [ ] Mother’s home [ ] Father’s home [ ] With Guardian

Parents’ Marital Status: [ ] Married [ ] Single [ ]  Divorced

**Please check ALL options you are interested in**:

When do you want to start? Click here to enter text. Date: Click here to enter a date.

[ ] M-F Chrysalis Program Half Day 8:30am to 12:30pm (ages 3-5)

[ ] M-F 2:30pm to 6:00pm After School Program 2:30pm to 6:00pm (ages 5-10)

[ ] M-F ABA Therapy Sessions (ages 2-15 in clinic, various ages in other settings)

[ ] M- TH Summer Camp- During the month of June (ages 3-15) (ages 16-18 Special Camp)

[ ] Respite Care- Some Saturdays- 10:00am to 2:00pm by appointment only)

Please describe your main concerns for your child and what you want them to get out of our program:

Click here to enter text.

Social/ Cultural Considerations: Are there any aspects of your culture or religion that we should know about that may affect how services are delivered at the center (Example: special diets, holidays, religious, beliefs, etc.)?

Click here to enter text.

**Child’s Medical Information (Required)**

Please list and describe any special needs, diagnoses or behaviors, medical conditions your child has:

Click here to enter text.

List Allergies:

Click here to enter text.

Does your child have seizures? [ ] Yes [ ]  No

If yes, what kind: Click here to enter text. How often:Click here to enter text.

List medications your child must take and for what: Click here to enter text.

Do medications need to be administered while your child is at the center? [ ] Yes [ ] No

How often are they given? Click here to enter text.

**Child’s Developmental Information (Required)**

Is your child potty trained?[ ]  Yes [ ]  No

 Can your child communicate their need to use the toilet? [ ] Yes [ ]  No

 Is your child using words or talking in sentences to communicate? [ ] Yes [ ] No

Do you use sign language? [ ] Yes [ ] No

Does your child need help eating? [ ] Yes [ ] No

Does your child have a special diet? If so, explain: Click here to enter text.

Is your child currently receiving therapies Check all that apply.

[ ] Speech [ ] Occupational [ ] Physical [ ] Sight [ ] Hearing [ ] Behavioral

Do you get therapies through your (IEP) Individual Education Plan? [ ] Yes [ ]  No

If yes, must email most current IEP to info@beckhombehaviorconsulting.com

Do you get therapies through your (IFSP) Individualized Family Support Plan through Babies Can’t Wait?

[ ]  Yes [ ] No

If yes, must email FSP to info@beckhombehaviorconsulting.com

Where are these services provided now? [ ] In the home [ ] At a school [ ] Pre-school

What school(s) or pre-school(s) is or has your child attended (please list):Click here to enter text.

What is the name of your child’s Early Interventionist (Babies Can’t Wait?)Click here to enter text.

**Behavioral Information/Concerns (Required)**

 Does your child have any special fears or behaviors that can harm them or others? List:

Click here to enter text.

Does your child look at you when you speak to them? [ ] Yes [ ]  No

Does your child follow your directions? [ ] Yes [ ] No

Is your child aggressive? [ ] Yes [ ] No

Do they: [ ] Bite [ ] Hit [ ] Run away [ ] Argue [ ] Tantrum/Meltdown

Are you using behavior analysis? [ ] Yes [ ] No

If yes, who oversees your program: Click here to enter text.

How do you discipline for misbehavior?

Click here to enter text.

**Please note, if placed in any of the Beckhom Behavioral Consulting, LLC programs, you will be required to sign a contract agreeing to abide by all the policies in the Beckhom Behavioral Consulting, LLC parent handbook including (but not limited to) the following. Please check that you have read and agree to:**

**Call the office for current tuition and registration rates.**

**Annual Registration**: Registration fees are non-refundable and are due at the time of registration and by September 1st of each year thereafter.

**Payments/Child Participation:** Full tuition is due at the start of each week (Monday), or the first day that your child attends. No reduction or refunds for days your child is sick, absent or for closed holidays.

**Returned Item Charge:** $30.00 will be charged for declined payments.

**Late Payment Fee:** $25.00 will be charged for tuition payments made after 10:00 am on Tuesday

**Termination:** Beckhom Behavioral Consulting, LLC has the right to terminate your contract at any time.

**Late Pick-up Fee**: $1.00 per minute will be charged if your child is here after your scheduled pick-up time.

**Contract Cancellations**: We require a 2-week paid notice before you withdraw your child. Notice must be in writing.

By signing, you agree and will comply with all information provided:

Print: \_\_ Click here to enter text. \_\_\_\_\_ Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter a date.

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**OFFICE USE ONLY**

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Date of All required Documents Received \_\_\_\_\_\_\_\_\_\_ Program Director’s Approval \_\_\_\_\_\_\_\_\_\_\_

Intake Meeting Scheduled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Registration/Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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