Application for Services

Andrews Center: Treatment and Learning Center

1722 West Front St.

Tyler, Texas 75702

Phone: 903 593-4004 Fax: 903-593-4121

Thank you for your interest in the Andrews Center Autism Programs. At the Treatment and Learning Center (TLC), we are dedicated to piecing together our East Texas Community by providing quality Applied Behavior Analysis (ABA) tailored to meet the needs of each child and teach them how to better communicate and interact with their environment, family, friends, and teachers.

**TLC’s Programs**

* The Focus program is a treatment model that provides short-term 1:1 ABA treatment for 6 hours a week for 6 months with some parent training and is usually funded through a grant from the Texas Health and Human Services Commission (formerly DARS) with a cost share.
* The Comprehensive program is a treatment model that provides 1:1 intensive ABA treatment 20-40 hours per week and is funded through insurance and private pay.

**Please select the funding source:**

Focus Program (6 hours per week, short time, focused treatment model)

Comprehensive Program (20-40 hours to the week, long term, comprehensive treatment model)

**My priority of treatment:**

Reduction of Interfering Behaviors

Increasing functional language and communication skills

Social skills training

Other: Please Specify.

**How did you hear about us?**

Referred by: Indicate referral source here.

Other:If you were not referred, how did you hear about us?

***ALL THE INFORMATION IN APPLICATION IS REQUIRED FOR SERVICES***

Today’s Date: Click or tap to enter a date.

## IDENTIFYING INFORMATION:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child’s Full Name:  Click to enter Child’s Name | Date of Birth:  MM/DD/YYYY | | Age in Years:  Click to enter Child’s Age | |
| Social Security Number:  XXX-XX-XXXX | Child’s Gender:  Click to enter Child’s Gender. | | Language Spoken in Home:  Click to enter primary and secondary languages, if applicable. | |
| Height:  Feet ft. Inches in. | Weight:  Enter approximate weight *lbs.* | | Race/Ethnicity:  Enter race/ethnicity. | |
| Address:  Click here to enter street address. | City:  Click to enter City | State:  Click to enter State | Zip Code:  Click to enter Zip Code | County:  Click to enter County. |

## DIAGNOSIS INFORMATION

|  |  |
| --- | --- |
| Diagnosis/Diagnoses:  Please indicate all diagnoses here. | Doctor who provided diagnosis:  Click to enter Doctor Name. |
| Age at Diagnosis:  Enter child’s age at diagnosis. | Year diagnosis was given:  Indicate year the diagnosis was given. |

## FAMILY INFORMATION

|  |  |
| --- | --- |
| Parent/Guardian Name:  Enter parent/guardian name. | Relationship to child:  Choose an item. |
| Address (if different from child):  Enter parent/guardian address. | City, State, Zip:  Enter city, state, zip. |
| Phone Numbers  Cell/Home: Enter cell/home.  Other: Other numbers. | Email Address:  Enter email address. |
| **Additional Parent/Guardian Information** | |
| Parent/Guardian Name:  Enter parent/guardian name. | Relationship to Child:  Choose an item. |
| Address (if different from child):  Enter parent/guardian address. | City, State, Zip:  Enter city, state, zip. |
| Phone Numbers Enter phone numbers. | Email Address: Enter email address. |
| Family Size\*:  Enter family size based upon tax return. | Gross Annual Income for Family\*:  Enter gross annual income based on tax return, if applicable. |

## FUNDING INFORMATION

|  |  |
| --- | --- |
| Does your child have CHIP? Choose an item. | CHIP Number: If yes, enter CHIP Number. |
| Does your child have Medicaid? Choose an item. | Medicaid Number: If yes, enter Medicaid Number. |
| Does your child have Medicare? Choose an item. | Medicare Number: If yes, enter Medicare Number. |

|  |  |
| --- | --- |
| Does your child have private insurance? Choose an item. | Insurance Company: Enter name of insurance company. |
| Insurance Phone Number:  Enter phone number. | Insurance Address:  Enter address. |
| Policy Holder Name and DOB:  Enter name and DOB of policy holder. | Relationship to Consumer:  Enter relationship of policy holder to consumer. |
| Policy Number:Enter policy number. | Group Number:Enter group number. |

*\*Based upon most recent tax return information.*

Please attach/send the following documentation:

## Requirements for all services:

Autism Diagnosis Report

Copy of insurance card

Copy of driver’s license

Proof of Income (tax return or 3 pay stubs)

Custody Agreements (if applicable)

Individualized Education Plan (if applicable)

## Requirements for the Focus Program:

o Proof of Texas residency

o Tax information or proof of annual income

o Any previous relevant assessments

* Speech assessment
* Occupational therapy assessment
* School evaluations

## Requirements for the Comprehensive Program:

o Autism Diagnostic paperwork

* ADOS2
* Done by medical doctor or PsyD

o Prescription of hours by primary care physician (usually 35-40 hours)

o Any previous relevant assessments

* Speech assessment
* Occupational therapy assessment
* School evaluations

Please initial:

Initial Here. I would like to be contacted by a current or former TLC parent regarding their experiences and what to expect.

Initial Here. I would like to be added to the TLC email list for information regarding events, trainings, etc.

*\*Feel free to visit our Facebook page at* [*https://www.facebook.com/treatmentandlearningcenter/*](https://www.facebook.com/treatmentandlearningcenter/)

*or our website at* [*www.tlcaba.org*](http://www.tlcaba.org)

Parent/Guardian Signature: Click here to sign document.

Date: Select Date.

*By typing my name above, I am indicating that I have confirmed all information above is correct to the best of my knowledge.*

*Please email form to TLC’s Intake Coordinator at:*

*whunt@andrewscenter.com*

*CC:*

*tlcaba@andrewscenter.com*