



Children’s Center for Autism

4910 Airport Ave., Bldg. F
Rosenberg, TX 77471

For Program Information: CCAAdmissions@texanacenter.com

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 waiting list as of the date on the application.

Today’s Date: _____

Applied Behavior Analysis (ABA) Treatment Options (descriptions on pages 4 and 5):

Comprehensive ABA Treatment Options-Insurance and private pay only (15-33 hours per week):

Location Preference:

- Rosenberg Location: 4910 Airport Ave, Rosenberg, TX
 - Serves children from the age of diagnosis-21 years old
- Sugar Land Location: 130 Industrial Blvd, Sugar Land, TX
 - Serves children from age of diagnosis-10 years old
- Fulshear area Location: 7440 FM 359 S., Fulshear, TX 77441
 - Serves children from age of diagnosis-8 years old

Focused ABA Treatment Options-HHSC Children’s Autism Program (less than 15 hours per week):

Location Preference:

- Rosenberg Location: 4706 Airport Ave, Bldg. C, Rosenberg, TX
- Fulshear area Location: 7440 FM 359 S., Fulshear, TX 77441
- Serves children ages 3-15 years old
- Medicaid and insurance policies that do not cover ABA

IDENTIFYING INFORMATION:

Child’s Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Sex: _____

Diagnosis(es): _____ Age at Diagnosis: _____

Ethnicity (required by funding source): _____

Current educational and/or treatment setting: _____

Name Parent/Guardian: _____

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

Date of Birth: _____ Social Security Number: _____

Relationship to applicant: _____

Phone: _____

Email: _____

Primary language spoken by parent or caregiver: _____

Primary language spoken by 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)

Medicaid and CHIP				<input type="checkbox"/> No Medicaid or CHIP coverage	
If this child is covered by Medicaid or CHIP, provide the following information:					
Medicaid	Medicaid ID:	Medicaid MCO name:	MCO Member ID:		
CHIP	CHIP ID:	CHIP MCO name:	MCO Member ID:		
Private Insurance				<input type="checkbox"/> No Private Insurance coverage	
If this child is covered by private insurance, provide the following information:					
Insurance company name:			Telephone number for providers:		
Primary policy holder's name:		Relation to child:		SS#	
Policy number:		Group number:		Effective date:	
Insurance company address:			City:		State: ZIP code:
Primary policy holder's employer:					

DIAGNOSTIC INFORMATION:

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)				

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			

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	
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	

BEHAVIOR STATUS ASSESSMENT:

Please check all that apply:

Communication:

- No discernible speech sounds (mute or 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: making noises/repetitive phrases, hand flapping, spinning, rocking, mouthing):

- 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

Does your child exhibit any of the following:

- Aggression to the Environment/Property (AE), such as throwing/turning over furniture, destroying materials, etc. If yes, ____ times per day, ____ per week
- Does not respond to sudden environmental changes (example: loud noises, presence/absence of people)
- 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
- Non-compliance. If yes, ____ times per day, ____ per week
- Theft. If yes, ____ times per day, ____ per week
- Other: _____

Program Information:

Comprehensive Program Descriptions: Private Pay/Insurance:

Summary: The Children’s Center for Autism is a 1:1 intensive Applied Behavior Analysis (ABA) program. The program operated year round except designated holidays. All programs are directed, managed, and supervised by a Board Certified Behavior Analyst (BCBA). Parents have open access to video monitoring of their child’s daily sessions. The principles of ABA are used to teach skills in the areas of appropriate behaviors, self-care, communication, social interaction, academics, classroom inclusion, etc. The Children’s Center also has an integrated pre-school on both the Sugar Land and Rosenberg campuses. This is an important component of our program and part of our continuum of services to prepare the children for mainstream school. Parent involvement is required on a weekly basis for a minimum of 30 minutes and therefore, training may also take place in the home, community, via telehealth, or school setting as needed.

- Setting/Hours: The Children’s Center is a clinic-based program. There is an array of schedule options ranging from 15-35 hours per week of ABA treatment.
- Fee for Service: private pay and insurance that covers applied behavior analysis treatment
- Age Requirements: Age of diagnosis-21 years
- Counties Served: there are no restrictions; family or school must provide transportation
- Required Diagnoses: no diagnosis required unless filing for insurance reimbursement
- Additional paperwork required before admission:
 - Proof of diagnosis on the Autism Spectrum by a PhD or MD; other diagnoses may be covered by insurance as well if your child does not have an ASD diagnosis.
 - 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 into the evaluation report; Texana can provide you with an example.
 - Completed Parent Manual including method of payment; these documents can be emailed or mailed to you. Beginning September 1, 2020, they will be reviewed and signed electronically.
 - Signed Payment Arrangement. Beginning September 1, 2020, this will be signed electronically.

Focused ABA Program Descriptions: 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 at least 1.5 hours of training each week or 3 hours every 2 weeks. Not meeting these requirements may result in dismissal 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:** There are no restrictions; however, 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
 - 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
 - Immunization Record: immunizations are not required, but we do require a record indicating which immunizations your child has received.
 - The following documents will be given to you to complete and return:
 - Signed Payment Arrangement. Beginning September 1, 2020, this will be signed electronically.
 - HHSC Enrollment Form
 - HHSC Cost Share Attestation Form
 - Completed HHSC Parent Manual including method of payment. Beginning September 1, 2020, this will be signed electronically.

Your child will be placed on the waiting list upon receipt of the completed application.

If returning by mail, please send to:

Texana Center

Attention: Ronda Kirklin-Phillips

4910 Airport Ave., Bldg. F

Rosenberg, TX 77471

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

Start dates will not be determined until all required paperwork is received.