Rochester Center for Autism
3640 9th Street NW
Rochester, MN 55901

Consultation Application

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Dear Parents/Guardians,

Welcome to the Rochester Center for Autism! We are grateful that you are interested in our program and look forward to meeting you and your family. The Rochester Center for Autism opened its doors in Rochester, MN in April of 2004. It is a center-based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. For those who do not qualify for early intervention services, the Center offers behavioral consultation by a Board Certified Behavior Analyst.

The first step in applying for consultation services is completing the necessary paperwork for the client. Please thoroughly fill out each page of the client application packet that is provided below. Once you have completed the forms you may submit it by mail, drop it off or fax it to the Center. I will be in contact with you when I receive the application packet to continue the intake process. If you have any questions along the way, please contact me during our scheduled business hours.

Thanks again for your interest in our program!

Sincerely,
Megan Mestad, MS, BCBA
Behavior Consultant/Lead Therapist
Rochester Center for Autism
(507) 424-3234 fax (507) 424-3235
meganmestad@rcenterforchildren.com

Consultation Application

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Start Date _____ (RCA will fill in)

Today's Date _____

Client: _____
Last Name First Name Initial

Sex of client: M___ F___ Age: _____ Birthday: _____ Client's Social Security #:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Cell #: _____

E-mail Address for Contact Information_____

Preferred Method of Contact (please rank in order)

Home Phone Number ____ Cell Phone Number ____ Work Phone Number ____ Email Address____

Siblings (list names and ages): _____

Parent/Guardian 1 Name: _____

Social Security #: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Parent/Guardian 2 Name: _____

Social Security #: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

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Payment Information

Please identify how you plan to fund consultation services.

_____**Family Support Grant** (*Please Provide Case Manager Contact Information)*

Case Manager Name_____ Phone Number _____ E-mail_____

_____**Consumer Support Grant** (*Please Provide Information Regarding the Fiscal Entity Provider)*

Fiscal Entity Provider_____ Contact Person _____ Phone_____

E-mail_____

_____**Personal Payment**

_____**Other (describe):**

_____**Private Insurance:** *(If you plan to use a private insurer, please fill out the following)*

**Please check with your insurance carrier to assess coverage of this service

Name of Primary Insurance _____

Member Number_____ Group Number: _____ Subscriber Name_____

_____**Medical Assistance:** *(If you plan to use Medical Assistance, please fill out the following)*

Name of Primary Insurance _____

Member Number_____ Group Number: _____ Subscriber Name_____

Name of Secondary Insurance _____

Member Number: _____ Group Number: _____ Subscriber Name: _____

Medicare #_____ Medicaid #_____

I prefer:
___ Pay my balance in full at time of service.
___ Pay my balance in full upon receipt of first statement.
___ Make payment arrangements prior to services being rendered.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____hereby authorize_____
(Name of Insured) (Name of Insurance Company)

To pay and hereby assign directly to Rochester Center for Autism all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all changes incurred. I further acknowledge that any insurance benefits, when received by and paid to Rochester Center for Autism will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized signature of Subscriber) (Date)

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Consultation Intensity

Please complete the form below to indicate how frequently you plan to access consultation services. This is just an estimate and can change at any time. The information you provide will help to determine the intensity and frequency of consultation you are seeking.

Please circle:

How frequently do you plan to access consultation services?

Onetime need Monthly Weekly Other

**If you circle other, please explain:*

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Medical Background

Does the client have any medical conditions? Yes / No

If yes, please list any special problems such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of.

Strengths

Please list the client's strengths:

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Main Concerns

Please list any concerns regarding the client at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the client's progress.

Possible Reinforcers

Please list all or any preferences that the client has shown and put * next to the ones that are highly preferred in each category. Be SPECIFIC as possible.

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

TOYS: (games, stuff animals, etc.)

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PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

ACTIVITIES: (reading books, listen to music, etc.)

OTHERS: (any special preferences not mentioned)

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Service Coordination

Client's Name: _____ Date: _____

Service Coordination:

Minnesota Statutes governing Children's Therapeutic Services and Supports require providers to coordinate services. If the client is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

Service	Number of Hours	Frequency
Special Education Services		
Child Welfare- Targeted Case Management (CW-TCM)		
Community Alternatives for Disabled Individuals (CADI) Waiver		
Personal Care Assistant (PCA)		
Mental Health- Targeted Case Management (MH-TCM)		
Recreational Therapy		
Psychiatrist		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Collaborative/Wraparound Services		
Other (explain)		

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Rochester Center for Autism Consent Form

I, _____, as parent/legal guardian of _____, give permission for my child/ward, (hereinafter "Participant") to receive consultation services through the Rochester Center for Autism. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to attend periodic meetings for review and revision of Participant's individual program. I also understand that I may withdraw Participant at any time. I understand that the Rochester Center for Autism reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I have given all emergency contact information to the Rochester Center for Autism.

I hereby agree to hold harmless and release from any and all liability, the Rochester Center for Autism, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as "the Rochester Center for Autism and its Sponsors"), for any injury or illness to the Participant, arising out of or in connection with his/her participation in the Rochester Center for Autism program. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant's rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant, against the Rochester Center for Autism program. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:

_____
_____
_____
_____

Parent/Guardian Name (please print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Client Notification of Privacy Rights
Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the " medical records privacy law," HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. _____

I have been offered a copy of the document and do not wish to have a copy at this time. _____

I understand I have the right to review the document before signing this acknowledgement form.

_____ _____
Client's Name (print) Client or Legal Guardian Signature

_____ _____
Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

HIPAA Privacy Rights Notification 06-

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FACE Sheet

Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

Name	
Birth Date	
Parent/Guardian	
Home Address	
Home Phone Number	
Cell Phone Number	
Work Phone Number	
Primary Insurance	Name:
	Member Number:
	Group Number:
Secondary Insurance	Name:
	Member Number:
	Group Number:
Hospital/Clinic Preference	
Primary Doctor	
Allergies	
Other Information	
Rochester Center for Autism	3640 9th Street NW (507)424-3234

Parent/Guardian Name (please print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Additional Information

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

- Copy of your child's insurance card(s)
- Medical documentation pertaining to the diagnosis of autism (only required if Medical Assistance or a Private Insurer is being used as a form of payment)
- Reports from other service providers (if applicable)
    - Speech therapy, school services, occupational therapy, etc.

Please contact the center if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Megan Mestad

Behavior Consultant/Lead Therapist

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Parent Support Group

The Rochester Center for Autism offers a support group for parents, guardians and others who work closely with children diagnosed with Autism.

- We welcome parents diagnosed with Autism of any age. The Autism support group looks to offer guidance, counsel, aid, comfort, understanding and bonding to all those who raise or work with children on the spectrum.
- Additionally, staff and volunteers trained by the Center provide childcare to help ensure all family members can attend. There is a small fee for utilizing the childcare services during these support groups.
- The group gathers once a month at the Rochester Center for Autism and is led by Edie Koch, Family Support Specialist, MHPr, an employee from the Center.
- Groups are sometimes focused on particular topics of interest (ex. how to deal with behaviors in the home) and other sessions provide an open discussion forum.

The Parent Support Groups typically run the last Wednesday of each month from 6:30-8:00. Most months during the school year a family meal is also served prior to the group to make our support groups more accessible for families. If you would like more information about the parent support group you may call the Center or contact Stephanie Schmidt at stephanieschmidt@rcenterforchildren.com

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Sibling Support Group

Rochester Center for Autism welcomes siblings of children with Autism Spectrum Disorders to join us for a monthly Sibling Support Group! At our sibling group, brothers and sisters will meet other siblings of children who have Autism Spectrum Disorders. They will get a unique opportunity to talk with other kids who understand what it's like to have a sib with special needs. Most importantly, they will also have a good time!

- The group is for brothers and sisters (including step-siblings) of children who have Autism Spectrum Disorders ages 4 and up. Those who attend the group are not required to be legal siblings. Families do not need to be clients of RCA to register.
- The cost is $10 for the first child and $5 for each additional child. This fee applies for both the Sibling Group as well as the childcare group.
- There will often be an optional family meal from 6-6:30, and is made available free of cost through generous funding from the RT Autism Awareness Foundation.
- The Sibling Support Group typically runs the last Wednesday of each month during the school year from 6:30-8:00, the same time as the Parent Group. A parent does not need to be in attendance at the Parent Group for the Sib to participate in the Sibling Group.

All Sibling Group participants must RSVP by the deadline to reserve their spot. To be added to the email list to receive notifications on the Sibling or Parent Support groups, please contact Stephanie Schmidt at 507-424-3234 or by email at stephanieschmidt@rcenterforchildren.com