

Please note:

- Applications will be reviewed in the order in which they are received.
- To guarantee that your application is reviewed you must return **this** application and required documents to continue in the application process.

Office Use Only:

Date Received: _____

Time Received: _____

**Early Learning Institute at Michigan State University
Application Form**

325 W. Grand River Ave., East Lansing, MI. 48823

Questions?

Call 517-355-1900

Child's Name:	Gender (circle): Male Female
Child's Birth Date: Child's Age:	Child's Social Security Number (req'd for insurance verification):
County of Residence:	
Parent/Guardian Name:	
Address:	Phone: (Home) _____ (Cell) _____ (Work) _____ Email: _____
How were you referred to our program?	

Family Information

Household Members: List name, age, and relation to child
Others who care for child: List name, age, and relation to child

Child's Health Information

Does your child have any significant health conditions? <input type="checkbox"/> NO <input type="checkbox"/> YES (please describe)
Does your child take medication? <input type="checkbox"/> No <input type="checkbox"/> Yes Medication _____ Dosage _____ Prescribing Doctor _____ Information we need to know: _____
Primary care physician: Doctor _____ Practice _____

Address: Phone:
Insurance Information
Primary Insurance Information:
Insurance Company: _____ Renewal Date: _____
ID Number: _____ Group Number: _____
Insurance Phone Number: _____ Contact Name: _____
Insurance subscriber name: _____
Subscriber's Social Security number / Date of Birth: _____
Relationship to Child: _____
Clinical Information
Please provide your child's current diagnosis: _____
Who conducted the evaluation: _____ ***Please attach copy of psychological evaluation completed by an Approved Autism Center of Excellence
Communication
Communication skills: Is your child (circle) Verbal Nonverbal
Describe level of communication (circle): <p style="text-align: center;">Approximations Single words Short phrases Conversational</p>
Does your child use alternative methods to communication (circle all that apply): <p>Picture exchange Sign language Pulling adults Pointing Electronic device (e.g., iPad)</p>
Behavioral Information
Does your child demonstrate any of the following?
Aggression: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____
Tantrums: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____
Fears/Anxiety: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____

Intense/Unusual Interests: No Yes Describe:

Repetitive Behaviors: No Yes Describe:

Property Destruction: No Yes Describe:

Social deficits / difficulty with peers: No Yes Describe:

Educational Issues: No Yes Describe:

Describe any other behavioral concerns you have:

Overall Health and Self-Care
Identify any concerns with the following for your child

Feeding/Eating: No Yes Describe:

Sleep issues: No Yes Describe:

Toileting: No Yes Describe:

Concerns regarding sibling interactions: N/A No Yes Describe:

Other concerns not noted above:

Does your child nap: No Yes If yes, what time and how long:

Child and Family Strengths

Child:

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Family:

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Availability for Parent/Family Training

We include parent/family engagement and training as part of all programming. Please note the days and times you are available to come to the Institute or for us to come to your home:

	In School <small>(These trainings would be scheduled between 8:30am to 4:00pm and take place at the ELI)</small>	In Home <small>(Meetings would be scheduled after 4:30pm and take place in your home)</small>
Monday:		
Tuesday:		
Wednesday:		
Thursday:		
Friday:		
Saturday:		
Sunday:		

Current and Past Services

Services Received	Agency	Contact Name and Number	Service Dates

Case Management (example: Early On, Social Work, CMH)			
School Setting			
Inpatient Hospitalization			
Occupational therapy			
Speech therapy			
Physical therapy			
Other (examples: diets, chelation, animal therapy, sensory integration)			

Completed Application Checklist

Please submit the following **required** documents

1. This completed application
2. AAEC Evaluation (confirming ASD diagnosis)

Submit to: Attn: ELI APPLICATION
325 W. Grand River
East Lansing, MI. 48823

OR

Katy Colaluca by e-mail at: **Kathryn@msu.edu** or Chris Darling by e-mail at:
darlin29@hdfs.msu.edu. **Subject line: ELI application**