Application Packet

Thank you for your interest in Northway Academy.

Northway Academy is a day program that offers applied behavior analysis (ABA) services for children with autism spectrum disorder (ASD) or related conditions. We believe that all children deserve the opportunity to grow and thrive in the community they call home. Each individual with ASD possesses unique strengths as well as areas requiring supports. Northway Academy's services are personalized to meet the unique needs of each individual.

Northway Academy is funded through the Early Intensive Developmental and Behavioral Intervention benefit (EIDBI) through medical assistance. You MUST be enrolled in medical assistance for your child to attend Northway Academy. For more information about medical assistance, please contact the county in which you reside.

In order to assess if Northway Academy is appropriate for your child, we require that the following admission packet be completed in its entirety. Once we have received your information, it will be reviewed and processed shortly thereafter. You will be contacted to discuss any questions or concerns that arise during the review of your child's information. If, after review, it is determined that your child may be appropriate for services, a member of our management team will contact you to discuss next steps.

Again, thank you for taking an interest in our program. Please feel free to contact us with any questions.

Instructions:

Please complete the following in its entirety. The following information is necessary for admission into Northway Academy, and BEFORE your child can be considered for services at Northway Academy. The following items are required before eligibility can be determined:

1. The screening forms included in this packet (each section filled out).
2. INITIAL and most recent Diagnostic Assessment.
3. Any other assessments, evaluations, or hospital records
4. IEP or any educational information.
5. Medical records, including most recent medical evaluation (well child check, must be within the last year).
6. A list of ALL current medications
7. All programs (previous and current), along with current treatment summaries (if applicable).
8. Any assessments/testing/treatment that has or is being done (i.e. OT/PT, Genetic testing, Neurological testing, etc.)
9. Any previous EIDBI treatment (e.g., previous CMDE, ITP) these forms must include completion date.

- Please send the information above via email to: NorthwayAcademyAdmissions@sevitahealth.com
- fax to 320-774-3465
- mail to:
  Northway Academy
  Attn: Intake Coordinator
  1775 Roosevelt Road
  St. Cloud, MN 56301

If you have any questions or need assistance please call our main office at 866-719-2117 or email the Intake Coordinator at NorthwayAcademyAdmissions@sevitahealth.com.
Thank you for your interest in Northway Academy. We look forward to working with you and your family.

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

Location of interest :

Application Information

Child's Name:	**Date of Birth:** / /	**Gender:**	**Social Security #** *(required for billing purposes)*: - -
Address:			
City, State:	**Zip**:		**County**:
Medical Assistance (needs to be straight MA/TEFRA without a health plan) **MA #:**			
Other Insurance:		**Group Number:**	
ID Number:		**Phone Number:**	
Parent 1 Name:		**Phone Number:**	
Email Address:			
Home Address (if different):			
City, State:			**Zip**:
Parent 2 Name:		**Phone Number:**	
Email Address:			
Home Address (if different):			
City, State:			**Zip**:
Person completing this form:		**Phone Number:**	
Relationship to Child:			
Who referred this child?			
Clinic Name/Date of most recent diagnostic assessment:			
Please describe this child's strengths:			
Please describe the child's biggest challenges:			
Please describe the family's desired outcomes:			

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

Child History Questionnaire

MEDICAL HISTORY		
Are immunizations up to date? ☐ **YES** ☐ **NO**		
List current allergies:		
Please list any medical conditions:		
List Current Medications:	**Dose / Time Administered**	**Reason:**
	/	
	/	
	/	
	/	
	/	
	/	
Previous Testing	**When / Where**	**Result:**
EEG	/	
CT Scan	/	
MRI	/	
Genetics	/	
List Previous Hospitalizations:	**Date (or age)**	**Reason:**
List Previous Surgeries:	**Date (or age)**	**Reason:**
Has your child has a severe head of bodily injury? ☐ **YES** ☐ **NO**		
If yes, please describe:		
Please describe your child's sleep:		
Please describe your child's appetite and eating habits:		

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

PREGNANCY AND BIRTH HISTORY

Birth Weight: | **Birth Length:**

Please list any concerns with birth:

NEURODEVELOPMENTAL HISTORY

Please describe any developmental concerns:

At what age did your child accomplish the following skills?

_____Smile	_ Roll	___Finger fed self
_____Babble	_ Sit alone	___Spoon feed self
_____Say first word	_ Crawl	___Drink from open cup
_____Put two words together	_ Walk	___Undress completely
_____Know first name	_ Kick a ball	___ Shoes on correct feet
_____Print name	_ Pedal tricycle	___ Ties shoes with bow
_____Dress completely		

Is your child toilet trained? Bowel ☐ Bladder ☐ Day ☐ Night ☐

Please describe with as much detail as possible any behavioral concerns:

Please list any special equipment your child requires:

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

SCHOOL HISTORY	
Name of current school/preschool?	
Current Grade:	**Teacher's Name**:
Has your child been retained? ☐ **No** ☐ **Yes** **If yes, when:**	

PREVIOUS SCHOOLS YOUR CHILD HAS ATTENDED		
Grade	**School**	**Academic Performance**
K		☐ Below Ave. ☐ Average ☐ Above Ave.
1st		☐ Below Ave. ☐ Average ☐ Above Ave.
2nd		☐ Below Ave. ☐ Average ☐ Above Ave.
3rd		☐ Below Ave. ☐ Average ☐ Above Ave.
4th		☐ Below Ave. ☐ Average ☐ Above Ave.
5th		☐ Below Ave. ☐ Average ☐ Above Ave.
6th		☐ Below Ave. ☐ Average ☐ Above Ave.
7th		☐ Below Ave. ☐ Average ☐ Above Ave.
8th		☐ Below Ave. ☐ Average ☐ Above Ave.
9th		☐ Below Ave. ☐ Average ☐ Above Ave.
10th		☐ Below Ave. ☐ Average ☐ Above Ave.
11th		☐ Below Ave. ☐ Average ☐ Above Ave.
12th		☐ Below Ave. ☐ Average ☐ Above Ave.

Check any special education services your child receives:

☐ **Current IEP** ☐ **OT** ☐ **Vision** ☐ **Title 1 Math**
☐ **Resource** ☐ **PT** ☐ **Title I Reading** ☐ **Speech/Language**

Has your child had educational testing? ☐ **Yes** ☐ **No**

If so, what were the results?

Describe current academic concerns reported by child's teachers:

Describe current behavioral concerns reported by child's teachers:

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

SOCIAL HISTORY

This child currently lives with:

PRIMARY CARETAKER

This is the child's : ☐ **Biological Family** ☐ **Adoptive Family**
☐ **Foster Family** ☐ **Group Home**

Please check any stressful situations your child has experienced with the last year:

☐ Death of family member ☐ Parents separation ☐ Change in parent(s) employment
☐ Major health change in family member ☐ Parents' divorce
☐ New family member ☐ Domestic violence ☐ Moving to new location
Other**:**

BEHAVIORAL CONCERNS

Behavior (please specify behavior)	Onset (age)	Frequency
Self-Injurious Behavior:		
Aggression:		
Property Destruction:		
Inappropriate Vocalization:		
Pica (eating inappropriate objects):		
Elopement:		
Other:		

Please describe any related injuries, consequences, or damage caused by the above behaviors:

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

PRIOR PROFESSIONAL CONTACT

Has your child ever been seen by any of the following professionals?

Psychiatrist / Child Psychiatrist: ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

Developmental/Behavioral Pediatrician: ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

Psychologist / Child Psychologist: ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

Speech Therapy: ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

Occupational Therapy: ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

Physical Therapy: ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

Other:_____ ☐ ***Yes*** ☐ ***No***
Name:
Location:
Reason for visit:
Dates:

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

FAMILY HISTORY

Please check any of the following conditions that are or have been present in the child's immediate or extended biological family.

	SIBLINGS	MOTHER	FATHER	MOTHERS RELATIVES	FATHERS RELATIVE
Developmental Delay	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐
Special Education	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐
Deafness	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
TIC/Tourette's	☐	☐	☐	☐	☐
Enuresis (Bedwetting)	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
HIV OR Aids	☐	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Dementia / Alzheimer's	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐

NORTHWAY ACADEMY
AUTISM SERVICES FOR CHILDREN

WHAT MY CHILD LIKES				
Category	**Item / Activity**	**Favorite**	**Likes**	**Does Not Like**
Toys				
	Toys with lights	☐	☐	☐
	Toys that spin	☐	☐	☐
	Toys with music	☐	☐	☐
	Toys that beep	☐	☐	☐
	Toys with sirens	☐	☐	☐
	Toys with car sounds	☐	☐	☐
	Dolls/action figures	☐	☐	☐
	Playing or trading cards	☐	☐	☐
	Puzzles	☐	☐	☐
	Legos/blocks	☐	☐	☐
	Board games	☐	☐	☐
	Educational games	☐	☐	☐
	Toy vehicles	☐	☐	☐
	Arts & crafts	☐	☐	☐
	Stuffed animals	☐	☐	☐
Activity with Child				
	Dress up	☐	☐	☐
	Being spun	☐	☐	☐
	Swinging	☐	☐	☐
	Wrestling	☐	☐	☐
	Running	☐	☐	☐
	Being tickled	☐	☐	☐
	Pretend play	☐	☐	☐
	Read to	☐	☐	☐
	Sung to	☐	☐	☐
	Told a story	☐	☐	☐
	Attention	☐	☐	☐
Other				
	Mirror	☐	☐	☐
	Shiny objects	☐	☐	☐
	Fuzzy objects	☐	☐	☐
	Playing in water	☐	☐	☐
	Bubbles	☐	☐	☐
	Lighted objects	☐	☐	☐
	Cold things	☐	☐	☐
	Hot things	☐	☐	☐
Electronic				
	Video/computer games	☐	☐	☐
	Music	☐	☐	☐
	Television	☐	☐	☐

Consent for Release of Information

Name of Individual:_____

I,_____ (name of client or guardian in the case of a child or incompetent adult), authorize **Northway Academy** to disclose and/or obtain from:

Name: _____
Agency: _____
Address: _____

Description of Information to be disclosed:

_____Assessment
_____Diagnosis
_____Psychosocial Evaluation
_____Psychological Evaluation
_____Psychiatric Evaluation
_____Treatment Plan or Summary
_____Current Treatment Update
_____Medication Management Information
_____Presence/Participation in Treatment
_____Nursing/Medical Information
_____Educational Information
_____Discharge/Transfer Summary
_____Continuing Care Plan
_____Progress in Treatment
_____Demographic Information
_____Progress Notes
_____Other_____
_____Other_____
_____Other_____
_____Other_____

For the purpose of:

_____Treatment/Service Planning
_____Ongoing treatment
_____Insurance/benefit/funding source approval
_____Other, please specify: _____
_____
_____

By this release, I am not giving permission for the receiver of this information to re-disclose this information to any third party. I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time and that in any event this consent expires automatically one year from the date below. I understand that this information may be transmitted via email.

_____
Individual Receiving Services **Date**

_____
Parent/Guardian **Date**

_____
Witness **Date**

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_____Demographic Information
_____Progress Notes
_____Other_____
_____Other_____
_____Other_____
_____Other_____

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_____Continuing Care Plan
_____Progress in Treatment
_____Demographic Information
_____Progress Notes
_____Other_____
_____Other_____
_____Other_____
_____Other_____

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_____Ongoing treatment
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