

## Early Intervention Program APPLICATION FOR SERVICES

Thank you for your interest in Society for Autism Support and Services.

Society for Autism Support and Services' Early Intervention Program (EIP) provides individualized, intensive programming funded by Alberta Education and Family Support for Children with Disabilities, including Early Childhood Services (ECS), Specialized Services, and Behavioural/Developmental Supports. We provide a developmentally appropriate, activity based, and family focused program to support children who have a diagnosis of Autism Spectrum Disorder and their

Please indicate which program you are interested in and complete the corresponding sections of the application:

**Early Childhood Services (ECS) Program (Preschool or Kindergarten)**  
Please complete the following sections of the application form:

A       B       E

**Specialized Services and Early Childhood Services (ECS) Program**  
Please complete the following sections of the application form:

A       B       C       E

**Behavioural/Developmental Supports and Early Childhood Services (ECS) Program**  
Please complete the following sections of the application form:

A       B       C       E

**\*The following programs are only available to children who are under 3 years of age and not old enough to qualify for ECS or do not have an ECS program already in place**

**Specialized Services Only Program\***  
Please complete the following sections of the application form:

A       B       D

**Behavioural/Developmental Supports Only Program\***  
Please complete the following sections of the application form:

A       B       D

**Toddler Model (Scholarship Funded)\***  
*Scholarships for the Toddler Model are only available to children who do not currently have FSCD services*  
Please complete the following sections of the application form:

A       B

Before we can process your application, we require additional documentation. Please include the following:

- Photo of your child
- Letter of Diagnosis
- Most recent Assessment Reports
- Most recent Individual Program Plan or Individual Service Plan (if currently in a program)
- Copy of your child's Birth Certificate

FSCD (please choose one)

- Approved for funding from FSCD, please include confirmation (e.g., copy of approval letter and hour approval)
- Applied to FSCD but have not heard from them. Applied \_\_\_\_\_(dd/mm/yyyy)
- Have not yet applied

We will contact you once we have received all the required documentation.

## A. GENERAL INFORMATION

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**CHILD'S NAME:** \_\_\_\_\_  
*(AS IT APPEARS ON BIRTH CERTIFICATE)*

**DATE OF BIRTH:** \_\_\_\_\_ **ALBERTA HEALTH CARE NUMBER:** \_\_\_\_\_  
*(YYYY/MM/DD)*

**BIRTH CERTIFICATE NUMBER:** \_\_\_\_\_

**ISSUING COUNTRY:** \_\_\_\_\_

**PARENT/GUARDIAN NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_  
*(YYYY/MM/DD)*

**ADDRESS:** \_\_\_\_\_  
*(STREET ADDRESS, CITY, PROVINCE, POSTAL CODE)*

**HOME PHONE:** \_\_\_\_\_ **MOBILE PHONE:** \_\_\_\_\_

**WORK PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**PARENT/GUARDIAN NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_  
*(YYYY/MM/DD)*

**ADDRESS:** \_\_\_\_\_  
*(STREET ADDRESS, CITY, PROVINCE, POSTAL CODE)*

**HOME PHONE:** \_\_\_\_\_ **MOBILE PHONE:** \_\_\_\_\_

**WORK PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**Languages spoken within the family home:** \_\_\_\_\_

**Any other siblings (and their date of birth), family members, or caregivers living in the home:**

**Please describe your family's long-term goals for your child:**

## B. DEVELOPMENTAL PROFILE/MEDICAL INFORMATION

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**DIAGNOSIS:** \_\_\_\_\_

**DIAGNOSING PROFESSIONAL:** \_\_\_\_\_

**DIAGNOSIS DATE:** \_\_\_\_\_  
(YYYY/MM/DD)

**INTERESTS:**

Please describe your child's interests.

**COMMUNICATION:**

Please describe how your child communicates with you and others in his/her life (e.g. children, extended family, etc.)

**BEHAVIOUR:**

Please list any behavioural and/or safety concerns and how they are currently managed.

**SELF-HELP SKILLS:**

Please comment on your child's skills in the following areas.

Mealtime: \_\_\_\_\_

Dressing: \_\_\_\_\_

Sleep habits: \_\_\_\_\_

Toileting: \_\_\_\_\_

**MEDICAL INFORMATION:**

**It is my/our understanding that my/our child is free from communicable diseases**

Family Physician: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_  
(YYYY/MM/DD)

**ALLERGIES:** \_\_\_\_\_

Please list any other pertinent information (seizure disorder, childhood illnesses, etc.):

## PROGRAMS AVAILABLE

### **C. COMBINED PROGRAM: SPECIALIZED SERVICES or BEHAVIOURAL/ DEVELOPMENTAL SUPPORTS AND EARLY CHILDHOOD SERVICES (ECS)**

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Society for Autism Support and Services' combined program integrates Specialized Services or Behavioural/ Developmental Supports and Early Childhood Services (ECS), running Monday through Friday. Programming occurs in the home environment, in the community, as well as in our specialized classroom environment at Society for Treatment of Autism. Funding is provided by FSCD for Specialized Services or Behavioural/Developmental Supports and from Alberta Education for an ECS program. This program serves children between 2 years, 8 months and 6 years of age. Specialized Services or Behavioural/Developmental Supports hours are based on the child's specific needs, as approved by FSCD.

Has your child received prior Specialized Services or Behavioural/Developmental Supports?

No

Yes (if yes, please specify below)

Name of Service Provider: \_\_\_\_\_

Is your child currently attending a preschool?

No

Yes (if yes, please specify below)

Name of Preschool: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### **D. SPECIALIZED SERVICES or BEHAVIOURAL/DEVELOPMENTAL SUPPORTS ONLY**

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Society for Autism Support and Services' Specialized Services or Behavioural/Developmental Supports Only Program runs Monday through Friday. Programming occurs in the home environment and in the community. Funding is provided by FSCD. This program serves children under 3 years of age with no ECS program in place. Program hours are based on the child's specific needs, as recommended by FSCD.

Has your child received prior Specialized Services or Behavioural/Developmental Supports?

No

Yes (if yes, please specify below)

Name of Service Provider: \_\_\_\_\_

Who is your current FSCD Worker? \_\_\_\_\_

Application completed by: \_\_\_\_\_

Parent/Guardian Name

## E. AUTHORIZATION TO RELEASE INFORMATION

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Please complete this release if you are applying for Early Childhood Services (ECS).

I/We, \_\_\_\_\_, authorize Society for Autism Support and Services to disclose and receive the following information about my/our child, \_\_\_\_\_

- Letter of Diagnosis
- Most recent Assessment Reports

Please list which reports have been provided to Society for Autism Support and Services.

The reports/documents listed above will be submitted to Alberta Education for the purpose of applying for funding (Program Unit Funding) pre-approval.

I understand that this information will be disclosed and received for the purposes of determining my/our child's therapy needs and possible further treatment.

I am aware of the risks or benefits of consenting or refusing to disclose information. I also understand that I may revoke this consent at any time. Please choose one of the following options:

- This consent will expire on: \_\_\_\_\_ (YYYY/MM/DD)
- This consent will not expire except by my revocation.

Signed on \_\_\_\_\_, in the city of \_\_\_\_\_.

(YYYY/MM/DD) (CITY)

Parent/Guardian Name

Parent/Guardian Signature

Parent/Guardian Name

Parent/Guardian Signature

Witness Name

Witness Signature