Temple Memorial
PEDIATRIC CENTER

Temple Memorial Pediatric Center
1710 Moores LN
Texarkana, Texas 75503
(903) 794-2705

Autism Services Screener

Child's name: _____ Date: _____

Has your child been assessed for any disability including Autism? Y/N

If Yes, what type of assessments were given and what were the results?

_____
_____
_____

Assessor's name: _____ Affiliation: _____

Child's age at time of assessment or date of assessment:

Did the assessment include a measure of developmental status/ability? Y/N

Did the assessment include a measure of school readiness/achievement? Y/N

Do you have any medical concern regarding your child? Y/N

If Yes, please describe: _____

_____

What other services does your child currently receive and where/who delivers theses services?

Check all that apply:

- ☐ Occupational therapy: _____
- ☐ Physical therapy: _____
- ☐ Speech therapy: _____
- ☐ Early Childhood intervention: _____
- ☐ Preschool program for children with disabilities: _____
- ☐ Other preschool/daycare: _____
- ☐ Counseling/Psychiatric services: _____

My Child's Communication

☐ Does not speak ☐ Speaks in 1-2 word phrases ☐ Speaks in longer phrases, hard to understand ☐ Speaks age-appropriately

Describe how your child communicates wants and needs: _____

_____
_____

Describe your communication concerns: _____

_____
_____

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My child's social interactions

- ☐ Seems uninterested in others
- ☐ Watches others, but limited interactions
- ☐ Initates interactions, but doesn't seem to understand how to interact with others his/her age

Describe how your child interacts with peers and adults: _____

_____

_____

Describe any concerns you have about your child's social interactions: _____

_____

_____

My child's challenging behaviors include

- ☐ Aggression
- ☐ Property destruction
- ☐ Non-Compliance (e.g. saying no, ignoring requests)
- ☐ Leaving designated areas
- ☐ Tantrum (e.g. screaming, crying, dropping to floor)

Describe your concerns about your child's challenging behavior: _____

_____

_____

My child's dietary or medical restrictions:

_____

_____

_____

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Request for Autism Services

Date _____

Child's Name _____ DOB _____(age____) Sex: M F

Parent name(s) _____

Address _____

Phone number _____ (home/cell/work)

Phone number _____(home/cell/work)

Email address _____

Referring/Primary Care Doctor:

Name: _____ Phone Number_____

Insurance Information:

Company: _____ Phone Number _____

Primary Insured _____ DOB_____

ID# _____ Group _____

OFFICE USE ONLY

TMPC a provider? Y / N ABA covered? Y / N Active Date: _____

Referral needed? Y / N Pre-cert/auth needed? Y / N

Co-Pay $_____ Deductible: _____

Out of pocket: _____

Notes:_____

_____

_____

Claims Address: _____

Spoke with: _____ Date_____ Reference #_____

TEXAS
Health and Human Services

Form 6000
April 2017-E

Children's Autism Program Enrollment

If multiple children in the household are being enrolled in the Children's Autism Program, use a separate enrollment form for each child.

Family Information

Child's First Name:	Middle Name:	Last Name:	Birth Date:

Parent or Guardian's Name:	Relationship to Child:

Phone:	Email:	Child's Sex: ◯Female ◯Male

Address:	City:	State:	ZIP Code:

Diagnosis:	Age at Diagnosis:	Language Spoken:	Race and/or Ethnicity:

Proof of Texas residency:	County:	Family size:

Income Information

Select all that apply:

☐ Gross Income ..... Amount:

☐ Allowable Deductions ..... Amount:

☐ Adjusted Gross Income ..... Amount:

Insurance Information

Do you have CHIP? ◯Yes ◯No	CHIP Number:	
Do you have Medicaid? ◯Yes ◯No	Medicaid Number:	
Do you have Medicare? ◯Yes ◯No	Medicare Number:	
Do you have insurance? ◯Yes (If yes, complete insurance information below.)	◯No	
Insurance carrier's name:	Policy holder's name:	
Referral source:	Previous ECI services: ◯Yes ◯No	

Signature

I certify that the statements made for the Children's Autism Program Enrollment application are true and correct to the best of my knowledge.

Parent's, guardian's, or caretaker's signature: Date of signature:

For Office Use Only

Case ID number:	Enrollment date:

Children's Autism Program
Family Cost Share Attestation Worksheet

Instructions to Contractors: If the family has an income tax return, use the adjusted gross income to determine the cost share. If the family does not have an income tax return, complete this form with the family to determine the annual income and deductions for the family. The parent or guardian of the child must sign the form attesting to the contractor that the information they provided on this form is correct.

Gross Income for the Year

Total the monthly income received by the individuals included in the family size, from whatever source, that is considered income by the Internal Revenue Service before federal allowable deductions are applied. Multiply the monthly income by 12 to come up with the annual gross income. A copy of the family's paycheck stubs or other forms of documentation need to be submitted with this form to confirm gross income reported.

Income Type	Parent 1	Parent 2	Child and Other Dependent(s)	Total
Wages, salaries, tips				$
Self-employment income				$
Unearned income such as retirement benefits or child support				$
Unemployment benefits				$
Dividends and interest				$
Other: SSI or other disability income such as Social Security due to disability or Veteran's disability is not countable income but make note that the family receives it.				$ 0 (not countable)
			Grand Total	**$**

Allowable Deductions

Allowable deductions include expenses not covered by insurance. The deductions must be recurring during the service period and may be medical or dental expenses to alleviate or prevent a physical or mental defect or illness. The costs limited to the following expenses:

- diagnosis, cure, alleviation, treatment, or prevention of disease;
- treatment of any affected body part or function;
- legal medical services delivered by physicians, surgeons, dentists, and other medical practitioners;
- medication, medical supplies, and diagnostic devices; and
- transportation to receive medical or dental care.

Allowable Deduction Type	Parent 1	Parent 2	Child and Other Dependent(s)	Total
Medical or dental expenses not covered by insurance (as determined by the above criteria)				$
Co-pays, co-insurance, and deductibles				$
Medical or dental debt that is being paid on an established payment plan				$
Childcare and respite expenses				$
Costs and fees associated with the adoption of a child				$
Court-ordered child support payments for children who were not counted as family members or dependents in calculating the adjusted income and family cost share amount				$
			Grand Total	**$**

Adjusted Income (used to determine Family Cost Share)

Gross Income	$	- Allowable Deductions	$ -	= Adjusted Income	$

I attest the information included on this form is correct.

Parent (or guardian) signature: _____ Date: _____