



**Baylor Autism Resource Center  
Applied Behavior Analysis  
(ABA) Therapy Program**

**Please see the enclosed information and  
application for more information.**

## The Baylor Autism Resource Center (BARC) Applied Behavior Analysis (ABA) Therapy Program

Baylor University graduate students in the ABA specialization program will provide ABA therapy to selected participants under the supervision of Board Certified Behavior Analyst, Dr. Tonya Davis.

Individual, one-hour therapy sessions will be provided twice per week to each client at the BARC on Baylor University campus. Baylor University campus closings and holidays will be observed. Please note that this program is NOT intended to replace an in-home ABA program, but instead to supplement such programs and other therapy programs that the client may be receiving.

Therapy goals will be selected by parent/caregiver, and progress monitoring results will be provided twice throughout the semester.

Applicants must have a diagnosis of a developmental disability, including, but not limited to autism, PDD-NOS, intellectual disability (i.e., mental retardation), Down Syndrome, or Rett Syndrome. The program has limited openings.

Applications will be reviewed, and accepted applicants will be placed with an available therapist or on the waitlist on a first come, first serve basis. Clients will be notified of acceptance and/or placement after application review.

Cost: \$50 registration & \$7 per session\*\*

\*\*Fees subject to change

For more information, contact Dr. Tonya Davis:

Tonya\_Davis@baylor.edu

254-710-6166

## Application Instructions

The following documents must be complete:

- Application
- Parental/Legal Guardian Release (for minor participants only)
- Medical Information & Release
- Confidentiality Protection Form

Applications may be submitted by email, fax, or mail.

Dr. Tonya Davis  
One Bear Place # 97301  
Waco, TX 76798  
Tonya\_Davis@baylor.edu  
Phone: 254-710-6166  
Fax: 254-710-3265

# Baylor Autism Resource Center (BARC) Applied Behavior Analysis (ABA) Therapy Program Application

Participant's Name: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Guardian's Name: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Address: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Gender: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade Level (if applicable): \_\_\_\_\_  
(MM/DD/YYYY)

Parent/Caregiver Phone Number (cell phone, if available): \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Participant Lives with: \_\_\_\_\_ Mother & Father \_\_\_\_\_ Mother \_\_\_\_\_ Father  
\_\_\_\_\_ Other/Legal Guardian (please specify): \_\_\_\_\_

List other children in the household:

Name: _____	Age: _____	Name: _____	Age: _____
Name: _____	Age: _____	Name: _____	Age: _____
Name: _____	Age: _____	Name: _____	Age: _____

How did you hear about the ABA therapy program? \_\_\_\_\_  
\_\_\_\_\_

Which days of the week and times do you prefer for your child to attend? Please note that daytime appointments are available and highly encouraged. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Identify participant's favorite foods, activities, items, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please identify participant's current skill level. Check one:

Adaptive Behavior Skills:

	Independent	Needs Reminders/Instruction	Needs Physical Assistance
Toileting	_____	_____	_____
Hand Washing	_____	_____	_____
Dressing	_____	_____	_____

Communication Skills (check all that apply):

- \_\_\_\_\_ No Speech sounds                      \_\_\_\_\_ Babbles (non-words)                      \_\_\_\_\_ Says 1 – 10 recognizable words
- \_\_\_\_\_ 10+ 1-word phrases                      \_\_\_\_\_ 2 – 3 word phrases                      \_\_\_\_\_ Short sentences or more
- \_\_\_\_\_ Imitates words & sounds                      \_\_\_\_\_ Echolalia (nonfunctional repeating of sounds)
- \_\_\_\_\_ Primary mode of communication is verbal language
- \_\_\_\_\_ Primary mode of communication is sign language. If yes, approximate number of signs: \_\_\_\_\_
- \_\_\_\_\_ Primary mode of communication is pictures/PECS. If yes, approximate number of pictures: \_\_\_\_\_
- \_\_\_\_\_ Primary mode of communication is electronic communication device. If yes, approx. # of buttons: \_\_\_\_\_

Challenging or Problem Behaviors of Concern (list and rate):

1. _____	Mild	Moderate	Severe
2. _____	Mild	Moderate	Severe
3. _____	Mild	Moderate	Severe
4. _____	Mild	Moderate	Severe
5. _____	Mild	Moderate	Severe
6. _____	Mild	Moderate	Severe
7. _____	Mild	Moderate	Severe
8. _____	Mild	Moderate	Severe

Identify current therapies the participant currently receives (including other ABA therapy). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the participant received ABA therapy in the past? Provide explanation if desired. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Identify and describe five high-priority goals that you would like to see your child meet during ABA therapy. \_\_\_\_\_

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**OPTIONAL:** Describe any unique financial needs that influence your child's need for the Baylor Autism Center's free ABA therapy program. \_\_\_\_\_

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Applications may be submitted by email, fax, or mail.

If selected, fees and all required forms will be due by the first day of therapy. An individualized fee schedule will be created for clients that choose to pay for sessions on a monthly basis. To request to pay the fees in installments, please contact Dr. Tonya Davis.

Dr. Tonya Davis  
One Bear Place # 97301  
Waco, TX 76798  
Tonya\_Davis@baylor.edu  
Phone: 254-710-6166  
Fax: 254-710-3265



**MEDICAL INFORMATION AND RELEASE  
BAYLOR AUTISM RESOURCE CENTER  
MINOR OR ADULT PARTICIPANT  
(PLEASE COMPLETE FORM IN BLUE OR BLACK INK)**

NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH: \_\_\_\_\_  
(MONTH) (DAY) (YEAR)

HEALTH INSURANCE CARRIER: \_\_\_\_\_

POLICY NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

PERSONAL PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

PHYSICIAN'S PHONE NUMBER: \_\_\_\_\_  
(AREA CODE) (NUMBER)

**PARENT, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE  
MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY. PLEASE CONTACT:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

HOME TEL: \_\_\_\_\_ WORK TEL: \_\_\_\_\_ CELL TEL: \_\_\_\_\_  
(AREA CODE) (NUMBER) (AREA CODE) (NUMBER) (AREA CODE) (NUMBER)

Please list and explain any chronic or acute medical problems (Continue on back if needed): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any allergies to food, pollen, or medications: \_\_\_\_\_  
\_\_\_\_\_

List any medications being taken at present: \_\_\_\_\_  
\_\_\_\_\_

I ACKNOWLEDGE THE PARTICIPANT'S IMMUNIZATIONS ARE CURRENT: \_\_\_\_\_ YES \_\_\_\_\_ NO

**I or MY CHILD plan to attend The Baylor Autism Resource Center hereinafter referred to as "the center." I fully realize that injury or illness could result from or during MY or MY CHILD'S participation in the center. In case of accident or illness, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.**

\_\_\_\_\_  
(ADULT PARTICIPANT or PARENT/LEGAL GUARDIAN'S SIGNATURE)

PLEASE PRINT THE CENTER PARTICIPANT NAME: \_\_\_\_\_

IF MINOR, PLEASE PRINT PARENT'S NAME: \_\_\_\_\_

**Baylor University**  
**Baylor Autism Resource Center**  
**Applied Behavior Analysis Therapy**  
**Confidentiality Protection Form**

An important part of training graduate students to become successful applied behavior analysis (ABA) therapists is to provide them with various field experiences to implement ABA therapy. Specifically, this request is to allow a graduate student therapist from Baylor University to provide ABA therapy to your child, under the supervision of at least one Board Certified Behavior Analyst (BCBA). Please note, that supervision consists of informal collaboration and intermittent observation; therefore, a supervising BCBA will not be present at all therapy sessions.

Therapy sessions and activities may be discussed during graduate class meetings and supervision meetings. You should also know that the graduate students are educated on ethical responsibility and the importance of confidentiality. Therefore, the name(s) of you, your child, your family, or your child's school will not be used in any written documents. In addition, the outcomes of the therapy program will not be placed in your child's school files, discussed with teachers or your principal, and will have no direct effect on your child's education.

If you decide after signing the consent form that you do not want to have your child participate, you have the right to inform the graduate student and contact the ABA therapy program director, Dr. Tonya Davis, and remove your child from the program.

Progress monitoring meetings between you and your child's graduate student therapist will provide you with the opportunity to discuss the activities and goals of therapy; however, you also have the right to discuss such information at any time by contacting the graduate student who works with him/her. You should interpret any discussions with caution since the graduate student is learning how to work with children with developmental disabilities and if you desire more information, please contact the supervising BCBA or the ABA therapy program director, Dr. Tonya Davis, at any time.

If you have any questions or concerns, please feel free to discuss them with the graduate student or myself (Dr. Tonya Davis, Baylor University, 710-6166).

\_\_\_ I agree to allow my child to participate in the ABA therapy program.

Parent Signature \_\_\_\_\_

Participant Signature \_\_\_\_\_

Graduate Student Signature: \_\_\_\_\_