



**The Baylor Autism Resource
Center is Proud to Announce the
Introduction of the
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.

Therapy will be provided September 13, 2010 – November 29, 2010; however, Baylor University campus closings and holidays will be observed.

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. Applicant selection will be based on severity of need, appropriateness of ABA to accomplish goals, and financial need.

Cost: \$50 registration and supply fee

The \$50 registration & supplies fee will be due on the first day of therapy. **Please DO NOT submit payment with application.**

Applications are due on September 3, 2010.

Selected participants will be contacted by September 9, 2010.

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 (must be postmarked on or before September 3, 2010).

Selected participants will be contacted by September 9, 2010.

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 or words)
- _____ 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. _____

OPTIONAL: Describe any unique financial needs that influence your child’s need for the Baylor Autism Center’s free ABA therapy program. _____

Applications may be submitted by email, fax, or mail (must be postmarked on or before September 3, 2010). Selected participants will be contacted by September 9, 2010.

If selected, a one-time registration & supplies fee of \$50 is required to provide expendable materials for the participant. Registration fees and all required forms will be due by the first day of therapy. To request to pay the registration fee in three installments, please contact Dr. Tonya Davis. Please submit payment by check payable to Baylor University.

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 a 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: _____