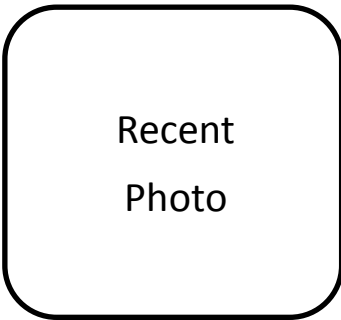




Mail to: Quest Kids
500 E. Colonial Dr.
Orlando, FL 32803
Fax: 407.218.4303



Program Application *(Please fill out completely)*

NOTE: Applications not submitted with all required paperwork may cause delay in consideration.

Date _____ How did you hear about us? _____

Child/Family Information

Child's Full Name _____

DOB _____ Gender: Male Female

Address _____

County _____ Phone _____

Responsible for Fee Payment _____

Primary Contact Phone _____ Primary Contact Email _____

Parent/Guardian Name _____ Relation to Child _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Occupation _____

Parent/Guardian Name _____ Relation to Child _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Occupation _____

Grandparent Name(s) _____

Address _____

Phone _____ Email _____

Grandparent Name(s) _____

Address _____

Phone _____ Email _____

Insurance Information

Please list ALL insurances (starting with your primary insurance) and attach a copy of the front and back of the card as well as a copy of the script for diagnosis and ABA therapy.

Insurance Name _____ Subscriber _____ DOB _____

Dependent Name _____ DOB _____

ID Number _____ Group Number _____

Phone Number _____

Medicaid *(Please attach the AHCA letter approving ABA therapy if applicable as well as a copy of the front and back of the Medicaid card.)*

Dependent Name _____ DOB _____

ID Number _____

Demographic Information

The following information is for reporting purposes only and will be kept strictly confidential. Quest Kids does not discriminate on the basis of race, gender, religion, national origin or family income.

Household Type:

Race/Ethnicity:

Household Income:

County of Residence:

Married/Couple

African-American

Less than \$10,000

Orange

Single Female

Asian/Pacific Islander

\$10,000—\$14,999

Seminole

Single Male

Caucasian

\$15,000—\$19,999

Osceola

Extended/Multi-Family

Hispanic/Latino

\$20,000—\$29,999

Lake

Legal Guardian/Other

Indian Sub-Continent

\$30,000—\$49,999

Legal Other

Multi-Racial

\$50,000—\$74,999

Native American

\$75,000—\$99,999

Other

More than \$100,000

Number of People in Household:

Children: _____ Male _____ Female

Adults: _____ Male _____ Female

Total _____

Medical Information

Doctor's Name _____ Phone _____

Address _____

List any information regarding the child's gestation and delivery (i.e. premature birth, complications): _____

List any medical or diagnoses:

_____ Date _____

_____ Date _____

_____ Date _____

List any medications the child is currently taking. Attach a separate piece of paper if you need more space. *(Please attach a script with diagnosis and/or ABA referral)*

Medication(s)	Dosage	Date Prescribed	Reason
---------------	--------	-----------------	--------

Medication(s)	Dosage	Date Prescribed	Reason
---------------	--------	-----------------	--------

Medication(s)	Dosage	Date Prescribed	Reason
---------------	--------	-----------------	--------

Name of diagnosis physician _____

Autism Diagnosis Yes No Date of diagnosis _____

Other Diagnosis _____ Date of diagnosis _____

List any hospitalizations, surgeries or other medical illness:

_____ Date _____

_____ Date _____

_____ Date _____

List any allergies your child may have to food, medication or environment: _____

Does/is the child:

- No Yes** Require the use of an EpiPen?
No Yes On a special diet?
If **yes**, give examples: _____
- No Yes** Refuse food?
If **yes**, give examples: _____
- No Yes** Weight range within normal limits?
If **no**, give examples: _____
- No Yes** Vision within normal limits?
If **no**, give examples: _____
- No Yes** Hearing within normal limits?
If **no**, please explain: _____
- No Yes** Ambulatory (able to walk without assistance)?
If **no**, please explain: _____
- No Yes** Toilet trained?
If no, please explain: _____

Language:

- No Yes** How does your child ask for what he or she wants? Points Leads Verbal
 Pictures Other _____
- No Yes** If **words** are used, how many? _____
- Can your child identify items?
No Yes If **yes**, how many? _____
- Can your child answer social information (what is your name, how old are you, etc.)?
If **yes**, give examples: _____
- No Yes** Can your child talk to you about what they did today?
If **yes**, give examples: _____
- No Yes** Will your child comply with simple requests (please come here, wait, give me the item)?
If **yes**, please explain: _____

Does/is the child:

Behavior:

No **Yes** Is your child aggressive?
If **yes**, give examples: _____

No **Yes** Does your child try to hurt themselves or others (hits their head, bite, etc.)?
If **yes**, give examples: _____

No **Yes** Does your child have frequent tantrums?
If **yes**, how long do they last? _____

No **Yes** Has your child engaged in property destruction (breaking items)?
If **yes**, give examples: _____

Availability

Please list all availability:

Monday	From _____ to _____
Tuesday	From _____ to _____
Wednesday	From _____ to _____
Thursday	From _____ to _____
Friday	From _____ to _____

Authorization

I certify that the information in this application is complete and accurate.

Parent/Guardian Signature

Date