Waitlist Form

2475 Palm Bay Rd, Suite 232, Palm Bay, FL 32905 Office: 321-914-4055,
Fax: 321-473-8829
Email all documents to: admin@efac15.com

Today's Date: _____

Child's name: _____, **Age**: _____, **Date of Birth**: _____

Parent's Name: _____

Phone: _____, **Email**: _____

Home address (Street, City, State and Zip-code):

_____

Does your child live here? Yes or No

Disability/Medical Diagnosis:

Check all that apply					
	(ASD) Autism Spectrum Disorder		(ADD) Attention Deficit Disorder		
	(ADHD) Attention Deficit Hyperactivity Disorder		(IDD) Intellectual Developmental Disorder		
	Global Developmental Delay		Auditory Processing Disorder		
	Language Disorder		Down Syndrome / Fragile X Syndrome		
Other Diagnosis:					

What insurance do you currently have?
Cigna, Blue Cross Blue Shield, Aetna, United Health Care, CMS, Sunshine, Ambetter, Tricare, Other: _____

Is your child enrolled in the Family Empowerment Scholarship for students with Unique Abilities (FES-UA)?
Yes or No

FES-UA ID #: _____

Language spoken at home (circle all that apply): English, Spanish, Other:

Does your child respond to their name? Yes or No

Do they look at you when you talk to them? Yes or No

Communication (circle all that apply)**:** Verbal, Vocal, Sign language, Electronic device, Picture board, Other: _____
Communication (circle all that apply): Speaks in sentences, Requests with words, Labels items and/or people, Answers questions, Points to items, Babbles, Other: _____

Ambulatory: Yes or No

If not, how do they get around (circle all that apply): Walker, Push Wheelchair, Electric wheelchair, Other: _____

Does your child toilet independently: Yes or No

If no, do they (circle all that apply): Have a colostomy bag, Wear a diaper, Need toilet training, Other: _____

Does your child receive any of these services? (circle all that apply): Applied Behavior Analysis, Speech Therapy, Occupational therapy, Physical therapy, Other: _____

Is your child currently enrolled in a school or childcare? Yes or No?

If so, what is the school's name? _____

Academics (what grade level is your child at developmentally): _____

Do they have an IEP? Yes or No

Main Areas of concern (circle all that apply): Following directions, Eating with utensils, Toilet training, Social skills, Proximity interactions, Loud noises, Repetitive movements, Aggression towards others, Hitting themselves, Chewing on items, Tantrums, Transitioning, Verbal communication, Eating more foods, Doesn't sleep well or not long

What upsets your child?

_____

_____

What are your child's preferred items or activities?

_____

_____

Please email a copy of your child's Comprehensive Diagnostic Evaluation (CDE), prescription for ABA services, and a copy of your insurance card (front and back).

Only families/children with all documents submitted and in order will be contacted for a tour or considered for enrollment.
