# PART A: APPLICATION FORM

**Instructions for Completing Referral Package:** Please send the completed referral package to their home school. The referral package may also be submitted to Student Services via fax (613-354-9850) or via e-mail ([ABAgroups@alcdsb.on.ca](mailto:ABAgroups@alcdsb.on.ca)).

Parents/caregivers will be contacted once an appropriate group for their child/youth is arranged. Please note groups offered in-person will occur during non-instructional time during the school day (e.g. at recess & nutrition break) to students from the same classroom cohorts. Space in a group is not guaranteed.

**For questions or additional information regarding the program, please contact:**

Katie Bremner, BCBA at [kbremner@alcdsb.on.ca](mailto:kbremner@alcdsb.on.ca) or 613-813-3155

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| **CHILD/ YOUTH INFORMATION** | | | | |
| **Name of Child/Youth:**  Click or tap here to enter text. | | | **Date application was completed:**  Click or tap to enter a date. | |
| **Gender:**  Click or tap here to enter text. | **Date of Birth (mm/dd/yyyy):**  Click or tap here to enter text. | | **Age:**  Click or tap here to enter text. | **Grade:**  Click or tap here to enter text. |
| **Child/Youth’s Learning Model for the 2020-2021 School Year:**  Remote Learning  In-Person Learning | | | | |
| **School Child/Youth Attends:** Click or tap here to enter text.  **Name of Teacher:**Click or tap here to enter text. | | | | |
| **Is the child/youth currently receiving group or**  **individual services (private or public)?**  Yes  No  If so, please provide details:  Click or tap here to enter text. | | **Current Supports at School:** (EA, SLP, OT, Etc.)  Click or tap here to enter text. | | |

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| **MEDICAL/ PSYCHOLOGICAL INFORMATION** | |
| **Is your child/youth on any medications? If yes, please specify.**  Yes:  Click or tap here to enter text.  No  **Known Allergies:** | **Please list all of the child/youth’s diagnoses (including medical and psychological):** Click or tap here to enter text. |
| **Is your child/youth aware of their ASD diagnosis?**  Yes  No | |

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| **PARENT/ CAREGIVER INFORMATION** | |
| **Name:**  **Relationship to Child/Youth:** | **Name:**  **Relationship to Child/Youth:** |
| **Contact Information:**  Home:Click or tap here to enter text. Cell:Click or tap here to enter text. Email Address: Click or tap here to enter text. Address: Click or tap here to enter text. | **Contact Information:**  Home:Click or tap here to enter text. Cell:Click or tap here to enter text. Email Address: Click or tap here to enter text. Address: Click or tap here to enter text. |
| **Preferred Method of Communication:**  Phone Email No preference | **Preferred Method of Communication:**  Phone Email No preference |

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| **GROUP INFORMATION** | |
| **Preferred Skills Group:**  Social/ Interpersonal  *(i.e., asking a friend to play, suggesting an activity)*  Communication  *(i.e., beginning a conversation, taking turns in a conversation)*  Behaviour/ Emotional Regulation  *(i.e., knowing and identifying feelings)*  Daily Living Skills  *(i.e., personal hygiene, laundry, transportation)*  Group Readiness  *(i.e., listening, turn taking, waiting)*  Safety Skills Related to Covid-19  *(i.e. wearing a mask, physical distancing, handwashing)* | **Child/Youth’s Communication:**  Single Words  Short Phrases  Full Sentences  Non-Verbal |
| **Child/Youth’s Preferred Reinforcement:**  Please list some items/activities your child would be motivated to work for (e.g. stickers, points, food items, small toys, activities, etc.)  Click or tap here to enter text. |
| **Has your child/youth participated in a group setting in the past?** (select all that apply)  In-person group:Click or tap here to enter text.  Virtual group: Click or tap here to enter text.  No | **Preferred Service Delivery Model:** (Please note this section is for students doing in-person learning only. Virtual programming will be available for remote learners)  IN-PERSON ONLY with peers from child/youth’s classroom cohort (e.g. during non-instructional time i.e. recess and nutrition break)  VIRTUAL ONLY  Either in-person or virtual |

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| **CONSENT** |
| **Do you provide consent for ALCDSB ABA Program staff and/or placement students to observe your child/youth at school for assessment purposes (i.e. determining skills group goals and assessing generalization of skills)?**  Yes  No  **I understand that this consent is valid for one year from the signing date below. I understand that I may revoke consent at any time.**  **Signature of parent/guardian:** Click or tap here to enter text. **Date:** Click or tap to enter a date. |

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| **ADDITIONAL INFORMATION** |
| Please share any additional relevant information (e.g. your child’s preferred activities, safety concerns, etc.) and/or skills you would like to see focused on in upcoming groups. Suggested skills will be taken into consideration and will be incorporated as appropriate.  Click or tap here to enter text. |

# PART B: QUESTIONNAIRE

Please answer the following questions on your child/youth’s current skills. This information will assist in determining the appropriate group for your child/youth and target skills. Please note that you only need to answer the questions that are applicable to your child/youth.

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| **SKILL AREAS** |
| **Instructions:**  For each of the skills listed below, please indicate whether the child/youth never, seldom, sometimes, often or always uses the skill. This checklist will assist us in selecting the appropriate group and topics.  **Rating scale:**  1= My child/youth *never* uses the skill |
| 2= My child/youth uses the skill with *prompting* |
| 3= My child/youth *can* and *does* use the skill independently |

**Group Readiness**

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| **Listening and Following Directions** | 1 2 3  Comment:Click or tap here to enter text. |
| **Responding to Joint Attention**: Can the child look at an object that another person has directed their attention to? | 1 2 3  Comment:Click or tap here to enter text. |
| **Initiating Joint Attention:** Can the child point towards or look at an object, look to another person and then look back at the object of interest? | 1 2 3  Comment:Click or tap here to enter text. |
| **Imitation:** Can the child copy the actions of a peer or adult both spontaneously or when asked to? | 1 2 3  Comment:Click or tap here to enter text. |
| **Turn Taking:** Can the child give up his/her turn? | 1 2 3  Comment:Click or tap here to enter text. |
| **Waiting:** Can the child wait for his/her turn? | 1 2 3  Comment:Click or tap here to enter text. |

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| **Communication** | |
| **Listening:** Does the child/youth attend to someone who is talking? | 1 2 3  Comment:Click or tap here to enter text. |
| **Beginning a Conversation** | 1 2 3  Comment:Click or tap here to enter text. |
| **Ending a Conversation** | 1 2 3  Comment:Click or tap here to enter text. |
| **Asking for Help** | 1 2 3  Comment:Click or tap here to enter text. |
| **Having a Conversation: (**i.e., join in a conversation by asking a question or making a comment) | 1 2 3  Comment:Click or tap here to enter text. |
| **Conversational Manners: (**i.e., “thank you”, “please”, “you’re welcome”) | 1 2 3  Comment:Click or tap here to enter text. |
| **Negotiating:** Is the child/youth able to come up with a plan and compromise with another person? | 1 2 3  Comment:Click or tap here to enter text. |
| **Take Turns in a Conversation** | 1 2 3  Comment:Click or tap here to enter text. |
| **Respond Appropriately During a Conversation** | 1 2 3  Comment:Click or tap here to enter text. |
| **Understanding Nonverbal Behaviour:** Is the child/youth able to accurately recognize and interpret nonverbal cues? | 1 2 3  Comment:Click or tap here to enter text. |
| **Understanding Tone of Voice Cues** | 1 2 3  Comment:Click or tap here to enter text. |

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| **Public vs. Private:** Is the child/youth able to identify private versus public settings? | 1 2 3  Comment:Click or tap here to enter text. |

**Behaviour/ Emotional Regulation**

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| **Knowing their Feelings:** Is the child/youth able to identify their internal emotions? | 1 2 3  Comment:Click or tap here to enter text. |
| **Expressing their Feelings:** Does the child/youth express his/her internal feelings/emotions? | 1 2 3  Comment:Click or tap here to enter text. |
| **Use Relaxation/Coping Strategies**: Is the child able to use a relaxation/ coping strategy when they are mad/sad? | 1 2 3  Comment:Click or tap here to enter text. |
| **Dealing with Problems:** Is the child/youth able to come up with a possible solution to a problem? | 1 2 3  Comment:Click or tap here to enter text. |
| **Accepting “no”** | 1 2 3  Comment:Click or tap here to enter text. |
| **Redirecting Negative Thoughts:** Does the child/youth reframe negative thoughts into positive thoughts? | 1 2 3  Comment:Click or tap here to enter text. |

**Social/ Interpersonal Skills**

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| **Introducing Him/Herself** | 1 2 3  Comment:Click or tap here to enter text. |
| **Joining In** | 1 2 3  Comment:Click or tap here to enter text. |
| **Inviting Someone to Play** | 1 2 3  Comment:Click or tap here to enter text. |

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| **Playing a Game with Others** | 1 2 3  Comment:Click or tap here to enter text. |
| **Being a Good Sport:** (i.e., they win appropriately, say good game to others etc.) | 1 2 3  Comment:Click or tap here to enter text. |
| **Dealing with Losing** | 1 2 3  Comment:Click or tap here to enter text. |
| **Suggesting an Activity** | 1 2 3  Comment:Click or tap here to enter text. |
| **Sharing** | 1 2 3  Comment:Click or tap here to enter text. |
| **Apologizing to Others** | 1 2 3  Comment:Click or tap here to enter text. |
| **Responding to Teasing** | 1 2 3  Comment:Click or tap here to enter text. |
| **Giving a Compliment** | 1 2 3  Comment:Click or tap here to enter text. |
| **Accepting a Compliment** | 1 2 3  Comment:Click or tap here to enter text. |
| **Offering Help to Others** | 1 2 3  Comment:Click or tap here to enter text. |
| **Deciding What Caused a Problem** | 1 2 3  Comment:Click or tap here to enter text. |
| **Dating and Relationships** | 1 2 3  Comment:Click or tap here to enter text. |

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| **Personal Safety and Boundaries** | 1 2 3  Comment:Click or tap here to enter text. |

**Activities of Daily Living**

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| **Groceries** | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |
| **Meal Preparation** | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |
| **Dishes** | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |
| **Laundry** | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |
| **Transportation:** (i.e., taking public transit) | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |
| **Hygiene:** Hand Washing | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |

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| **Hygiene:** Brushing Teeth | 1 2 3  Comment:Click or tap here to enter text.  Independent  With assistance |
| **Other Daily Living Skills** | Resume Writing  Interview Skills  Budgeting |

*You will be contacted if a group appropriate for your child/youth is arranged. Please note that space in group is not guaranteed.*

# For questions or additional information regarding the program please contact:

Katie Bremner, Board Certified Behaviour Analyst Email: [ABAgroups@alcdsb.on.ca](mailto:nrobart@alcdsb.on.ca)

Phone: 613-813-3155

Fax: 613-354-9850