Spotlight Program

NortheastArc
Changing lives. Discovering abilities.

Spotlight Program Application

Interested in:

- ☐ School Year Program: September – June
- ☐ Summer Program: July-August (6 weeks)

Applicant

Child's Name: _____ Date of Birth: ____ /____ / ____ Gender: ____

School: _____ Grade: _____ Application Date: ____ /____ / ____

Race (circle): White Black/African A. Asian Latino Other: _____

Language for individual:_____ Language for household:_____

Family Contact Information

Primary Contact		**Secondary Contact**	
Parent/Guardian:		Parent/Guardian:	
Relationship:		Relationship:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Email:		Email:	
Preferred Contact:	□Cell □Home □Email	Preferred Contact:	□Cell □Home □Email

Additional Emergency Contact Information

Name: _____ Home Phone: _____

Cell Phone: _____ Relationship to Applicant: _____

Primary Health Insurance Information (Please Attached Copy of the Front and Back of your Card):

Insurance Plan: _____

ID#:_____

Subscriber: _____

Does your child receive ABA from another provider? _____

6 Southside Road Danvers MA 01923
Telephone Number 978-924-5843 Email ccurtin@ne-arc.org
www.ne-arc.org

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Diagnosis

□ ADHD
□ Anxiety
□ Asperger's Syndrome
□ Autism
□ Behavioral Disorder
□ Bipolar Disorder
□ Depression
□ High Functioning Autism
□ Learning Disability
□ Nonverbal Learning Disability
□ OCD
□ PDD/NOS

□ Other (please specify) _____

Does the individual have a diagnosis of Autism? □ Yes □ No
Is your child aware of his/her diagnosis? □ Yes □ No

Date Autism diagnosis was given? _____

Primary Care Physician	Physician	Phone

Diagnosing Physician	Diagnosing Physician	Phone

Please list any prescription and over-the-counter medications used (please list additional on back):

Medication	Dosage	Prescribed by:	Purpose	Start Date mm/yy

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Hospitalizations		
Medical or Psychiatric	**Date**	**Reason**

Allergies

Please list all allergies to medications, food, animals, environment etc.

_____

_____

Individual Needs

Please describe your child's current strengths, likes and interests:

_____

_____

_____

Please describe your child's most significant challenges and current areas of need:

_____

_____

_____

Please list any sensory issues that your child may have:

_____

_____

_____

Please inform us of any social or life changes that have occurred for your child (family, school, friends, etc.) within the past year:

_____

_____

_____

Please list your child's current personal care needs (e.g. bathing, grooming, dressing, toileting, etc):

_____

_____

_____

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Please list the specific factors or events that trigger frustration or anxiety for your child:

_____

_____

_____

Please describe any recent episodes of aggressive behavior towards self or others:

_____

_____

_____

Please describe any recent episodes of bolting or running away from others:

_____

_____

_____

Please describe effective responses and supports that help your child to be successful in emotionally or socially challenging situations:

_____

_____

_____

What services outside of school have you tried, or do you currently have in place?

_____

_____

_____

Please inform us of anything else you think we should know about your child (if your child needs support with personal care needs such as toileting or feeding)

_____

_____

_____

How did you hear about Spotlight?

_____

_____

_____ _____

Parent/Guardian **Date**

_____ _____

Applicant Signature (18 years and older) **Date**

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