FSU | EARLY CHILDHOOD AUTISM PROGRAM
PANAMA CITY

Date of initial contact:_____
Follow-up date:_____
Follow-up date:_____
Intake Person:_____

Application for Services (C1.2)

Please fill out application in its entirety and return to:

FSU ECAP Applications
4750 Collegiate Drive
Panama City, FL 32405
or by email to — fsuecap@fsu.edu

Parent Name(s):_____ M/F:_____

Child Name:_____ DOB:_____

Diagnosis: _____ Date Diagnosed:_____

School: _____ Grade: _____

Home Address: _____

_____

_____

How many hours of therapies are you requesting?_____

Phone: (h) _____ (w) _____

(c) _____ Email:_____

Funding Source (circle all that apply): ☐ FL Medicaid ☐ Out of Pocket/ Private Pay

Insurance (Please specify company/state: _____) ☐ None (scholarship needed)

Policy Number:_____ **Funding Source Contact Number**:_____

Availability: List all days and times your child is available for therapy (sessions are usually 2-3 hours and clinic hours are Monday-Friday 8am-5pm):

_____

_____

_____

_____

Needs: Comments on the child's communication ability, concerns, skills needed, etc.: _____

Previous Providers: ☐ ABA ☐ Speech ☐ OT ☐ Other: _____

Previous Provider Contact Information:

By signing below, I give permission to FSU ECAP to contact and request records from previous service providers.

Name	Signature	Date
_____	_____	_____

Additional Notes: