



HELP, HOPE, SOLUTIONS APPLICATION FORM

Child's name: _____ DOB: _____

Parent(s): _____

Phone #: _____ Email: _____

Diagnosis (if applicable) _____ Date submitted: _____

Services you are interested in (circle all that apply):

ABA Therapy Floor Time Therapy Blended Approach (ABA and Floor Time) Social Skills/Thinking Groups

Time slot(s) that fit(s) your schedule (circle all that apply):

Morning Afternoon Any time

Briefly describe your concerns:

List some of your child's strengths:

List some activities/situations your child struggles with:
